SUPPLEMENT
TO THE
BRITISH MEDICAL JOURNAL.

LONDON, SATURDAY, APRIL 20TH, 1929.

CONTENTS.

ANNUAL REPORT OF COUNCIL, 1928-29. *(For Contents see below.)*

SPECIAL NOTICE TO MEMBERS.

Every Member is requested to preserve this "Supplement," which contains matters specially referred to Divisions, until the subjects have been discussed by the Division to which he or she belongs.

MATTERS REFERRED TO DIVISIONS.

British Medical Association.

ANNUAL REPORT OF COUNCIL, 1928-29.

Preliminary.

ANNUAL MEETING, MANCHESTER, 1929.

1. The Annual Meeting, 1929, commences at Manchester on Friday, July 19th, under the Presidency of Mr. A. H. Burgess, F.R.C.S., M.Sc., Professor of Clinical Surgery, University of Manchester. The last occasion on which the Association met in Manchester was in 1902.

ANNUAL MEETING, CARDIFF, 1928.

2. The Council has expressed to the President, Sir Ewen J. Maclean; the Honorary Local Secretary, Dr. G. I. Strachan; the Honorary Local Treasurer, Dr. E. E. Brierley; their medical colleagues and the various lay persons and authorities who co-operated with them, the thanks of the Association for their efforts in making the 1928 Annual Meeting of the Association a success.

ANNUAL MEETING, 1930.

3. The Council reminds members that the Annual Meeting in 1930 is to be held at Winnipeg, Manitoba, beginning August 26th; that a warm welcome awaits every member of the Association who attends that meeting, which is regarded in Canada not only as a great medical event but as one of Imperial importance; and that the preliminary arrangements as regards the Sections have already begun.

The Annual Representative Meeting will be held at the B.M.A. House, London, at the usual time in July.

ANNUAL MEETING, 1931.

4. The Council at its July, 1928, meeting accepted the invitation from the Eastbourne Division to hold the Annual Meeting at Eastbourne in 1931.

NOMINATION OF SIR ROBERT PHILIP AS A VICE-PRESIDENT.

5. The Council recommends:—

Recommendation: That Sir Robert Philip, M.D., LL.D., F.R.C.P.E., Edinburgh, be elected Vice-President of the Association under Article 41 and By-law 74 as a recognition of his services as President during the year 1927-28.

HONOURS.

6. The Council has pleasure in announcing that during the present Session honours have been conferred upon the following members, to whom the congratulations of the Association have been sent:—

Baron.

Sir Berkeley G. A. Moynihan, Bart., K.C.M.G., C.B., M.S., LL.D., D.Sc., Leeds.

Companion of Honour.

Florence Elizabeth, Lady Barrett, C.B.E., M.D., M.S., B.Sc., London.

K.B.E. (Civil).

Charles Hubert Bond, C.B.E., D.Sc., M.D., F.R.C.P., LL.B., Brighton.

D.B.E. (Civil).

Miss Anne Louise McIlroy, O.B.E., M.D., D.Sc., London.

Knighthood.

Khan Bahadur Nasarvanji Hormasji Choksy, C.I.E., Bombay.

Carrick Hey Robertson, M.B., F.R.C.S., Auckland, N.2.

OBITUARY.

7. The Association has to deplore the loss of the following members :—

Name.	Offices held in the Association.
Sir Stewart Abram	Chairman of the Reading Division
Dr. Bertram Addenbrooke ...	Chairman of the Worcester Division
Dr. James Arnott	Member of the Executive Committee of the English Division
Dr. Arnold Wm. Montfort Auden	Chairman of the Leigh Division
Dr. George Balsillie	Secretary of the Kendal Division
Dr. Benjamin Pope Bartlett ...	Member of the Dorset and West Hants Branch Council
Dr. Wm. Mardon Beaumont ...	Chairman, Representative and Secretary of the Bath Division and Secretary of the Bath and Bristol Branch. Secretary 1896, Vice-President, 1905, and President, 1925, of Section of Ophthalmology
Dr. Leo Ferdinando Bianchi ...	Member of the Executive Committee of the Edinburgh and Leith Division
Dr. Humphrey Purnell Blackmore	President of the South Midland Branch
Dr. Thomas Burfield	Chairman of Eastbourne Division
Mr. Samuel Herbert Burton, F.R.C.S.	Vice-President of Section of Surgery, 1900
Sir Hector Clare Cameron, C.B.E.	Vice-President of the Glasgow and West of Scotland Branch. President of Section of Surgery, 1906
Dr. Donald Graham Campbell ...	President of the Northern Counties of Scotland Branch
Dr. James Chalmers	Vice-President of the North of England Branch
Dr. John Thomson Clark ...	Member of the Metropolitan Counties Branch Council
Dr. James Donaldson	Member of the Executive Committee of the Cleveland Division
Dr. John Templeton Dunlop ...	Member of the Executive Committee of the Newcastle-on-Tyne Division
Mr. Frederick Durham, F.R.C.S.	Member of the Executive Committee of the Westminster Division
Dr. Wm. Dyson	Member of Council and a President of the Yorkshire Branch. President of Section of Medicine, 1908
Lt.-Col. A. Edington	President of the Natal Inland Branch
Dr. Frederick Claude Evill ...	Chairman of the West Hertfordshire Division
Dr. Wm. Fergusson	Member of the Executive Committee of the Banffs, Moray and Nairn Division
Dr. Frederick Cecil Forster ...	Vice-President of the Dorset and West Hants Branch
Dr. Arthur Gale	Member of the Executive Committee of the Kingston-on-Thames Division
Dr. Howard Vivian Alexander Gatchell	Representative of the Mashonaland Division
Dr. Robert Wm. Beor Gibson ...	President of the Witwatersrand Branch
Col. Peter Broome Giles, C.B., V.D	Chairman of the Aylesbury Division
Dr. Kenneth Gillies	President of the Northern Countiesof Scotland Branch
Dr. Thomas Duncan Greenlees...	Member of Council and a Member of the Dominions Committee. Secretary and Treasurer of the Grahamstown and Eastern Province Branch. Vice-President of Section of Psychological Medicine and Neurology, 1910
Dr. Edwin Birchall Hastings ...	Chairman of the Tower Hamlets Division
Dr. Wm. Hay	Member of the Executive Committee of the Sunderland Division
Col. Wm. Thornborough Hayward, C.M.G.	Vice-President of the Association. Member of Council and President of the South Australian Branch
Dr. George Wm. Hill	Member of the Metropolitan Counties Branch Council. Vice-President of Section of Otology, 1890, and President of Section of Oto-Rhino-Laryngology, 1921
Dr. Thomas Edward Holmes ...	Vice-President of Section of Public Health, 1926
Dr. Arthur Henry Headley Huckle	Chairman of the Hastings Division
Dr. Wm. Brown Hunter ...	Vice-President of the Ulster Branch
Col. John Arnallt Jones, K.H.S.	Secretary of Section of Navy, Army and Ambulance, 1903
Dr. Nicholas Fletcher Kendall	Chairman of the Guildford Division
Mr. Wm. Smith Kerr	Chairman of the Sheffield Division. Secretary of Section of Laryngology, Otology and Rhinology, 1908
Dr. Edward Kershaw	Member of the Executive Committee of the Oldham Division
Dr. Robert Knox	Secretary, 1912, and Vice-President, 1920, of Section of Electro-Therapeutics, and President of Section of Radiology and Electro-Therapeutics, 1921
Dr. Andrew Little	Secretary of Bradford Division
Dr. John Macintyre	Vice-President of Section of Laryngology and Otology, 1906. Secretary, 1892, and President, 1922, of Section of Laryngology
Dr. Ian Donald Mackay... ...	Chairman and Representative of the Harrogate Division
Dr. Andrew John McNickle ...	Chairman of the Lambeth and Southwark Division
Dr. Wm. Walker Maxwell ...	Chairman of the Kingston-on-Thames Division
Dr. Echlin Storry Molyneux ...	Vice-Chairman of the Warwick and Leamington Division
Dr. James Ernest Moorhouse ...	Member of Council
Dr. Charles George Drummond Morier	Member of Council and of the Dominions Committee
Dr. Frank Mort	Member of the Executive Committee of the Cleveland Division
Colonel Bernard James Newmarch, C.B.E., C.M.G.	President of New South Wales Branch
Mr. Wm. Marshall Oakden ...	Chairman of the North Suffolk Division
Dr. Albert Tronson Ozzard ...	President of the British Guiana Branch
Dr. Joseph John Perkins, F.R.C.P.	Vice-President of Section of Medicine, 1923
Dr. George Newton Pitt, O.B.E., F.R.C.P.	Vice-President of Section of Pathology, 1902, and Vice-President of Section of Medicine, 1907
Dr. Clive Riviere, F.R.C.P. ...	Secretary, 1912, and Vice-President, 1924, of Section of Diseases of Children
Squadron-Leader Robert Lloyd Roe, O.B.E.	President of the Connaught Branch
Dr. Manecksha Rustomjee ...	Member of Ceylon Branch Council
Dr. Charles Wm. Smeeton, O.B.E.	Chairman of the York Division

Dr. James Wilkie Smith ...	President of the North of England Branch, and Chairman and Representative of the Newcastle-on-Tyne Division
Dr. George Smith Sowden ...	Secretary of the Banff, Moray and Nairn Division, and Member of the Scottish Committee
Dr. James Beveridge Spence, O.B.E.	President of Section of Psychological Medicine, 1901
Dr. James Stewart	Representative of the Lambeth Division and Member of the Executive Committee of the Richmond Division
Dr. Laura Stewart Sandeman ...	Member of the Executive Committee of the Aberdeen Division
Dr. Wm. Latimer Storey ...	Secretary of the Belfast Division. Member of the Propaganda Sub-Committee
Dr. George Sutherland ...	Vice-Chairman of the Islands Division
Dr. Wm. Smith Syme ...	Chairman of the Glasgow Central Division. Secretary of Section of Laryngology, 1922, and Vice-President of Section of Laryngology and Otology, 1924
Dr. Wm. Turner	Chairman of the Mid-Cheshire Division
Mr. Wm. Warwick Wagstaffe, O.B.E., F.R.C.S.	Member of the Executive Committee of the Oxford Division
Dr. Robert Lauder Mackenzie Wallis	Secretary of Section of Pathology and Bacteriology, 1923
Dr. Denis Walshe	Member of Council and of the Irish Committee. President of the South Eastern of Ireland Branch
Mr. George Edward Wherry, F.R.C.S.	Vice-President of Section of Surgery, 1920
Dr. Kenneth Bamford Williamson	Member of the Executive and Ethical Committees of the English Division
Dr. Wm. Wrangham, O.B.E. ...	Chairman of Bradford Division. Secretary of Section of Medicine, 1924
Dr. John Lister Wright	Member of the Executive Committee of the Portsmouth Division

Dr. John Arnold Molony Alcock, Dr. Alexander James Anderson, Dr. Noel Alexander Lewis Anderson, Dr. Percy Ashworth, Dr. Francis Edward Atkinson, Dr. Robert Alfred Edward Bacon, Dr. Thomas Baker, O.B.E., Dr. Monty Baranov, Dr. Wm. Barras, Dr. Francis Lawrence Bignell, D.S.O., Dr. Wm. Blackney, Lt.-Col. Charles Thomas Blackwell, R.A.M.C., Ret., Dr. Norman Laurence Boxill, Dr. Thomas Wallace Boyd, Dr. John Joseph Brennan, Dr. Harry Fielden Briggs, Dr. Joseph John Brownlee, Dr. John Kilpatrick Brownlees, Dr. George Macqueen Brunton, Lt.-Col. Cecil Edward Bulteel, O.B.E., I.M.S., Dr. Samuel Bullen James Bulteel, Capt. John Crawford Burns, Dr. Marjorie Thompson Burns, Dr. Lionel Cottingham Burrell, Dr. Wm. Burt, Dr. Thomas Arthur Cambridge, Dr. John Edward Campbell, Dr. Percival James Campbell, Dr. John Patrick Carraher, Dr. Louis Ely Reginald Carroll, Mr. Louis Lawrence Cassidy, F.R.C.S.Irel., Dr. Theodore Stewart Chambers, Dr. Christopher Childs, Dr. Donald Clark, Dr. Wm. Henry Clark, Dr. Sydney James Clegg, O.B.E., Dr. Charles Cochrane, Dr. Wm. Rex Collingridge, Dr. Wm. Cook, Dr. Henry Morris Cowen, Dr. Andrew Crawford, M.B.E., Dr. Thomas Joseph Croke, Dr. Norman Edward Culbertson, Mr. Francis Xavier Da Costa, F.R.C.S., Dr. Alfred Darlow, Dr. Shankar Ganesh Datar, Dr. Philip Lys Davies, Dr. Wm. Edward Davies, Dr. Wm. John Edwin Davies, Dr. Peter de Bruyn, Dr. Hinton De Silva, Dr. James Dewar, Dr. George Arthur Dickinson, Dr. Michael John Joseph Doran, Dr. Cornelius Duggan, Dr. John Watt Duncan, Surg.-Capt. John Christopher Durston, R.N., Ret., Flight-Lt. Brian Lamburn Edwards, R.A.F.M.S., Dr. Charles Maxwell Ekins, Dr. Frederick Wm. Emery, Dr. John Wm. Emmet, Dr. Gabriel Wm. Stahel Farmer, Dr. Wm. George Robertson Farquharson, Dr. Egbert H. Florance, Dr. Harvie Forrester, Dr. Francis Troughton Foster, Dr. Wilfrid Frederick Francis, M.C., Dr. Alexander Clow Fraser, Lt.-Col. John Campbell Fullerton, I.M.S., Ret., Dr. Edwin Saargood Fry, Dr. Robert Kinnear Hay Gillespie, Dr. Wm. Gilmore, Dr. Alexander Stewart Gordon, O.B.E., Dr. David James Graham, O.B.E., Dr. Samuel Lionel Green, Dr. Olive Gregg, Dr. Ernest Edward Griffiths, Dr. George Halket, Dr. Octavius Hall, Dr. David Hamilton, Dr. Francis Washington Everard Hare, Dr. Nathan Charles Haring, Dr. Francis Wm. Hartley, Dr. Richard Hedden, Dr. John McAskill Henderson, Dr. Alfred Herbert Heslop, D.S.O., O.B.E., Dr. Thomas Walmsley Heywood, Dr. Nancy Mabel Hield, Dr. Allen Holmested Hobbs, Dr. Wm. Seton Hodghton, Dr. Harold Heyworth Holden, Dr. John Hudson, Dr. Douglas Walter Hume, Dr. Bertram Fowler Hussey, Dr. Alec Jackson, Dr. David Jackson, Dr. Archibald Hamilton Jacob, Dr. Henry Wm. Jacob, Dr. Walter Jagger, Dr. George Richard James, Major Henry Daniel James, R.A.M.C., Ret., Dr. Wm. Arthur James, Dr. John Jones, Dr. Thomas Charles Jones, Surg.-Capt. Henry Arthur Kellond-Knight, R.N., Ret., Dr. Patrick Gabriel Joseph Kennedy, Dr. James Kerr, Dr. Harry Kerswill, Dr. John Wm. Krause, Dr. Archibald Buchanan Laidlaw, Dr. James Thomas Currie Laing, Dr. Charlie Lees, Dr. Douglas McEwan Leroux, Dr. Wm. Collins Lewis, Dr. Wm. Alexander Teao Lind, Dr. Walter Andrew Luke, Major Wm. Graeme Denroche McCall, M.C., R.A.M.C., Dr. Stanhope Hastings MacCulloch, Dr. Robert Kennedy McDougall, Dr. David McEachran, Dr. John Ferguson McFadyen, Dr. Alphonsus McGrath, Dr. Donald MacGregor, Dr. Alexander Ernest McKenzie, Dr. James McLachlan, Dr. James Rorison McLean, Dr. Roderick Macleod, Dr. John Malcolm Macpherson, Dr. James Marley, Dr. Thomas Morgan Martin, C.M.G., Dr. Noel Maudsley, Dr. John Walter Melville, Dr. Alexander Dunlop Miller, Dr. Edward Frederick Molony, Dr. Julius Moore, Dr. George Frederic Elliot Morgan, Dr. Wm. Alexander Morton, D.S.O., Dr. James Munce, Dr. Arthur Gordon McKay Murdoch, Dr. Alexander Napier, Dr. Alexander Nasmyth, Dr. Harold Bernard Newcombe, Dr. Wm. Thomas Joseph Newton, Dr. Francis John Nicholls, Dr. John Wyllie Nicol, Dr. John Pollock Nixon, Dr. Thomas Edward Nuttall, Dr. Marie Goodwin Orme, Dr. Wm. Alexander Orr, Dr. David Robert Oswald, Dr. John Owen, Dr. Albert Alexander Parry, Dr. Patrick Scanlan Pearse, Dr. Charles Victor Pearson, Dr. Thomas Eben Pemberton, Dr. Wm. Pinck, Dr. Reginald Arthur Pittard, Dr. Sydney Platts, Dr. Owen Pritchard, Dr. Wm. Clowes Pritchard, Dr. John Amos Puddyfoot, Dr. John Randle, Dr. Alexander Findlay Reid, Mr. Samuel Ian Hamilton Reid, Dr. Mohammed Mustafa Riad, Dr. Christopher Hugh Leete Rixon, Dr. James Stirling Robertson, Dr. Maurice George Robertson, Dr. Wilhelm Siegfrid Rorich, Dr. Wm. Caldwell Ross, Dr. John Cornwall Round, Dr. Arthur Rudd, Dr. Wilfrid Alan Russell, Dr. James Edmund Rutherford, M.C., Dr. Saroly Kumar Sanyal-Bey, R.N., Dr. John Daniel King Scott, Dr. Frank Randolph Seager, Dr. Lionel Sells, Dr. John Adolphus Sharp, Dr. Wm. Dwight Sharpe, Dr. Albert Sheppeard, Dr. Alexander Victor Shine, Dr. John Watson Simpson, Dr. Samuel George Sloman, Dr. Arthur Brown Smith, Dr. Henry Richard Smith, Dr. Heywood Smith, Major-General John Blackburne Smith, C.B., C.I.E., I.M.S., Ret., Dr. Sidney McKendrick Smith, Dr. Maurice Frederick Squire, Dr. James Stevenson, Dr. John Logan Stewart, Dr. Wm. Grant Stewart, Dr. James Stirling, Dr. Robert Andrew Stirling, Dr. George Wray Sudlow, Dr. Harold Saunderson Sugars, M.C., Dr. Frederick Thomas Thistle, Dr. Elsie Thomson, Major Charles Pinkerton Thomson, D.S.O., Dr. Douglas MacKenzie Thomson, Dr. James Hamilton Thomson, Dr. John Valerian George Brosman Tighe, Major Ronald Ernest Todd, R.A.M.C., Ret., Dr. Archibald Dixon Tomlins, Dr. Wm. Milne Tough, Dr. Gohal Govind Vatve, Dr. Derwent Hutton Ryder Waldron, Dr. Joseph Walker, Dr. Wm. Jack Osmond Walker, Dr. Joseph Brownlie Wallace, Dr. George Samuel Walton, Dr. Henry Ernest Watts, Dr. Winefred Furnival Wigglesworth, Dr. James Cam Wight, Dr. Richard Tudor Williams, Dr. Adam Wilson, Dr. Albert Wilson, Dr. James Wilson, Dr. John Besnard Wilson, Dr. Wm. Macknight Wilson, Dr. John Hearn Woodroffe, Dr. Douglas Wilson Wright, Dr. Walter Lionel Wyatt, Dr. Arthur David Yule, Dr. Robert Zuill.

SYMBOLIC STAFF OF THE ASSOCIATION.

8. The Treasurer (Mr. Bishop Harman) has kindly presented to the Association a symbolic staff which is intended to serve as the common sign of the Association when acting in a corporate capacity upon occasions such as the Church Service at each Annual Meeting, the visit to Canada, the opening of the extensions of the B.M.A. House and the Centenary celebrations. The Council has accepted this further manifestation of the Treasurer's generosity and devotion to the Association with a pleasure which it is sure will be shared by every member of the Association. The Council is arranging that the staff shall be formally received in Annual General Meeting at Manchester.

The staff is made on the plan of the ancient Roman standards—a symbolic device upon a long pole. The new standard displays the device which is the feature of the badge of the Association mounted upon an appropriate plinth and staff. The core of the device is the erect pine club—coiled around this in the characteristic figure of eight is the serpent. The device is

based upon an oblong rectangular plinth with deeply panelled faces and sides. The front panel bears the letters B.M.A. in raised Roman capitals; the back panel has the inscription in similar lettering: "THE STAFF OF THE BRITISH MEDICAL ASSOCIATION, Presented by N. Bishop Harman, F.R.C.S., Treasurer, 1929." The whole device is wrought in sterling silver. The serpent is silver-gilt. The eyes are jewelled with carbuncles. The shaft is of English oak wood, polished black, it has three silver screw joints to facilitate dismantling and carriage, and a silver ferule.

PAST PRESIDENT'S BADGE.

9. The Council is pleased to report that the President, Sir Ewen Maclean, has presented to the Association a Badge to be worn on suitable occasions by the Past President of the Association, who for one year on the termination of his Presidency is an Officer of the Association. The President has been warmly thanked for his gift and the Council is glad to think that the first and a most appropriate occasion on which the Badge will be worn will be during Sir Ewen's visit as the delegate of the Association to the Australasian Medical Congress in September next.

OPENING OF EXTENSION OF B.M.A. HOUSE.

10. It has been decided that there shall be a formal ceremony in connection with the opening of the extension of the B.M.A. House, probably in the early Autumn, and it is intended to place in the entrance of the extension a plaque commemorating the services of Sir Robert Bolam and others in connection with the acquisition and extension of the B.M.A. House. It has also been decided that the forward extensions of the House shall be known as Tavistock House North and Tavistock House South respectively.

CENTENARY CELEBRATIONS OF FACULTY OF MEDICINE, CAIRO.

11. The Council is glad to report that the Association was represented at these celebrations, which took place in December, 1928, by the Past President, Sir Robert Philip, and Sir William de Courcy Wheeler, both of whom received the Honorary Degree of Doctor of Medicine of the University of Cairo, this being the first occasion on which the University had conferred such degrees. Sir Robert Philip reported that the celebrations had been a great success, and that the representation of the Association and its Address of Congratulation had been thoroughly appreciated.

AUSTRALIAN CONGRESS OF THE ASSOCIATION.

12. The Council is specially pleased to report that the President, Sir Ewen Maclean, has kindly consented to represent the Association at the Australian Congress of the Association to be held in Sydney, September, 1929, and hopes to visit en route several other Oversea Branches.

DELEGATES OF ASSOCIATION TO CONFERENCES OF OUTSIDE BODIES.

13. The Council has during the past session appointed the following members of the Association as delegates representing the Association at the Conferences specified: Annual Conference of New Zealand Branch, February, 1929: Mr. W. Sampson Handley; Annual Meeting of Canadian Medical Association: Sir StClair Thomson and Mr. J. A. Cairns Forsyth; Fourth Imperial Social Hygiene Congress, London, 1929: Dr. H. G. Dain, Mr. N. Bishop Harman; Central Council for Health Education Conference, October, 1928: Dr. E. Lewys-Lloyd and the Medical Secretary; National Conference on Health and Welfare of the British Navy: Dr. H. G. Dain and the Medical Secretary.

APPOINTMENT DURING YEAR OF REPRESENTATIVES OF ASSOCIATION ON OUTSIDE BODIES.

14. The following appointments have been made by the Council during the year: Medical Committee of British Red Cross Society, London Clinic for Rheumatic Diseases: Dr. F. G. Thomson, Bath; Advisory Committee under Therapeutic Substances Act, 1925: Dr. C. O. Hawthorne; Council of Faculty of Insurance: Dr. H. B. Brackenbury; Committee of British Population Society: Dr. H. B. Brackenbury; Executive Committee of National Association for Prevention of Infant Mortality: Dr. E. R. Fothergill; Joint Tuberculosis Council: Dr. C. O. Hawthorne, Dr. A. Lyndon; Advisory Board of Medicine of University of Wales: Sir Ewen J. Maclean; Committee of Clinicians advisory to the Pharmacopœia Commission: Prof. W. E. Dixon, Mr. E. Lewis Lilley; National Campaign against Rheumatic Diseases Council: the Deputy Medical Secretary; National Ophthalmic Treatment Board: Mr. N. Bishop Harman and Mr. A. W. Ormond.

GUIDE TO QUALIFICATIONS IN PUBLIC HEALTH, TROPICAL MEDICINE AND HYGIENE.

15. Since the Council last reported, there has been published by the Association a *Guide to Regulations, Courses and Examinations for Qualifications in Public Health, Tropical Medicine and Hygiene in Great Britain and Ireland*, by Dr. Andrew Balfour, C.B., C.M.G., Director of the London School of Hygiene and Tropical Medicine, a piece of work in respect of which its author has laid the Association and profession under a debt of gratitude. Copies can be purchased (3/- post free).

ASSOCIATION PROFESSIONNELLE INTERNATIONALE DES MÉDECINS.

16. The Council submits in Appendix I the Report of the Medical Secretary on the proceedings of the Annual Conference of the above body held in Paris, 27th to 30th September, 1928. Members will be interested to learn that during the last few weeks the National Medical Groups in the following countries have joined the A.P.I.M.:—Greece, Palestine, and United States of America. The paragraphs in the report dealing with matters connected with the work of various Committees of the Association have been submitted to the several Committees.

THE MEDICAL SECRETARIAT.

17. In the ordinary course of events the Medical Secretary would retire, under the age limit, in May, 1931, but the Council has asked him to remain in office until after the Centenary Meeting in 1932 is over. The general question of the changes that will be necessary in the Secretariat is under consideration.

ATTENDANCES.

18. The Council submits a list of attendances at meetings of the Council from A.R.M. 1928 to April 3rd, 1929 (*see* Appendix II).

Finance.

19. The year 1928, whilst not unsuccessful from the point of view of the finances of the Association, has been a period of considerable activity and some financial strain. The Financial Statement for the year 1928 is set out in detail in Appendix III, which will appear in the *B.M.J.* Supplement, April 27th, 1929.

The various transfers to the Sinking Fund, Reserve, and for depreciation, have been made in accordance with the decisions taken in the last and previous years, and, owing to heavy expenditure of an unusual and non-recurring nature, a deficit of £266 19s. 8d. must be deducted from the Surplus Account.

The Sinking Fund stands in the books at £3,236 12s. 6d., but compound interest is now accumulating upon the annual premiums paid in, so that in the year 1967 a sum of £100,000 will be available towards the redemption of the Association's leasehold property.

A further sum of £5,000 has been credited to the Reserve Account for the extension of the work and premises of the Association, but the money representing this item has been utilized in connexion with the work now going on.

Redecoration of the existing house must be undertaken during this year under the terms of the Lease, and the usual allocation of £1,500 for this purpose has been made.

The membership increased during the year by 933, the total at 31st December, 1928, being 34,558. A very curious coincidence is that despite the increase in membership the number of those falling into arrears of subscription and the number paying up their arrears are exactly the same in 1928 as in 1927.

The income for the past three years has been as follows:

	£	s.	d.
1926	136,357	14	4
1927	143,721	7	1
1928	151,369	1	6

The expenditure for the same three years was:

	£	s.	d.
1926	134,484	13	2
1927	141,891	9	3
1923	151,636	1	2

BALANCE SHEET.

Liabilities.

20. The *Sundry Creditors* show a decrease of approximately £3,300, payments for machining and postage of JOURNALS having been made somewhat earlier than usual and thereby falling within the old year.

The market value of the Stocks held for the Reserve Fund was £25,710 at the 31st December, 1928.

Arrangements have been made for a loan from the Westminster Bank at bank rate to the extent of £77,500 until the 29th September, 1930, when a similar sum falls due to the Association from the New Zealand Government.

Assets.

21. *Leasehold Premises.*—Work upon the extension of B.M.A. House, Tavistock Square, has been pressed forward, and large payments are being made to the Contractors upon the certificate of the Architect and Surveyor. The depreciation rate has been maintained at the previous figure of £2,000.

Scottish House.—The work of converting Nos. 6 and 7, Drumsheugh Gardens for the purposes of the Association has been completed. Depreciation to the extent of £757 5s. 6d. has been written off.

Investments.—These investments remain at the figure in the Balance Sheet at 31st December, 1926, and have not been written up.

Purchase of Scholastic Shares.—Sir Robert Bolam, on behalf of the Council and in pursuance of the policy previously agreed upon, arranged the purchase of a further 31 shares of £10 each.

Furniture and Office Equipment.—The purchases during the year include an addressograph machine and two typewriters.

Subscriptions in Arrears.—The subscriptions carried forward as in arrear have decreased somewhat in value despite the larger membership, the number being 1,484 at 31st December, 1928, as against 1,652 at the end of 1927.

The item of £2,359 is represented largely by subscriptions of Overseas Members which may have been paid to the Branch Secretaries abroad but had not reached the Head Office before the end of the year.

Sundry Debtors for Advertisements.—The increase in Advertisement Revenue renders it advisable to add £250 to the Reserve for Bad Debts and Discounts, making a total reserve under this heading of £2,000.

INCOME AND EXPENDITURE ACCOUNT.

22. *Subscriptions.*—The subscriptions due for the current year show an increase of £3,216 14s., due to the increase in membership during 1928 and to variations in the classes to which members belong.

The subscriptions due for previous years which have been recovered in the year under review have again been shown separately, in order to demonstrate that the amounts shown in the Income and Expenditure Account as "Subscriptions written off" are by no means lost. Of the sum of £2,436 8s. 3d. carried forward in the Balance Sheet of 31st December, 1926, as "Subscriptions in arrear," no less a sum than £2,044 12s. was recovered during 1927. The balance of £391 16s. 3d. was included in the amount of £3,489 16s. 8d. written off in the Income and Expenditure Account at 31st December, 1927. A further sum of £227 1s. 3d. was received during 1928, which, together with the £1,840 19s. 6d. collected by the Head Office in respect of 1927 subscriptions written off, and £234 14s. 6d. recovered in respect of previous year's subscriptions, makes a total recovery of 884 subscriptions, representing £2,302 15s. 3d.

Thus, of the £2,436 8s. 3d. carried forward in the Balance Sheet of 31st December, 1926, £2,271 13s. 3d. has been recovered, leaving outstanding a sum of only £164 15s.

Similarly, out of the sum of £2,595 17s. 4d. carried forward in the Balance Sheet at 31st December, 1927, no less than £2,229 5s. 3d. was recovered during 1928, leaving outstanding only £366 12s. 1d.

Rents.—The five houses in Tavistock Square and Upper Woburn Place have been demolished in order to allow for the rebuilding.

ABSTRACT A.

23. *Representative Meeting.*—The attendances at the Cardiff Meeting for which fares were paid were considerably fewer than at Edinburgh, the figures being :

1926, Nottingham	165
1927, Edinburgh	207
1928, Cardiff	166

Annual Meeting.—The number of Sections at Cardiff was 18, as against 21 at Edinburgh.

Council.—The attendance at Council Meetings :

In 1926 incurred 203 railway fares.
In 1927 incurred 205 railway fares.
In 1928 incurred 241 railway fares.

But it must be remembered that the amount of the railway fares depends upon the distance travelled and many members of the Council from the South attended the Meetings in Edinburgh, the Association thereby having to pay high railway fares.

Secretaries' Conference.—The railway fares paid to Honorary Secretaries who were not members of Council or Representatives numbered :

In 1926, Nottingham	48
In 1927, Edinburgh	54
In 1928, Cardiff	39

Committees.—The various increases and decreases are shown in detail in the Abstract. The action taken in connexion with the General Medical Council election involved the Association in an expenditure of £242.

Of the expenditure incurred in connexion with the Insurance Acts Committee, the National Insurance Defence Trust repaid to the British Medical Association the following sums :

	£	s.	d.
Railway Fares	408	15	11
Printings	104	3	0
Sundries	22	8	3
	£535	7	2

ABSTRACT B.

24. *Charges on Bank Loan.*—As set out above, the Association has arranged with the Westminster Bank for a loan equal to the amount payable by the New Zealand Government. The progress of the building operations will naturally cause an increase in the interest payable.

Legal Charges.—The figure for 1927 includes the law costs of the libel action against the "Star" newspaper, and actions to prevent the exploitation of the name of the B.M.A. and its copyright book *Secret Remedies.*

A.P.I.M.—The subscription for 1928 to the A.P.I.M. was paid in accordance with the instructions of the Representative Body.

ABSTRACT C.

25. The housekeeping figures show but slight variation.

ABSTRACT D.

26. The decrease in the travelling and subsistence allowance to members of the staff in connexion with the Annual Meeting is mainly due to the shorter distance from London of the place of Meeting.

ABSTRACT E.

27. There have been increases in the cost of printing the N.H.I. certificates, Division and Branch Rules; and the *Guide to Public Health* was published during 1928.

ABSTRACT F.

28. To meet the increasing demand for books the Council decided to add to the subscription to Messrs. Lewis's Library, so that a larger number of volumes in current use are available.

JOURNAL ACCOUNT.—ABSTRACT G.

29. The following are the comparative figures for the BRITISH MEDICAL JOURNAL :

	1927.		*1928.*
Literary pages and Epitome ...	2,646	...	2,546
Supplement pages	532	...	576
Advertisement pages	2,882	...	3,146
	6,060		6,268

The revenue from advertisements has increased by £4,196, which was more than sufficient to meet the increasing cost of the preparation and dispatch of the JOURNAL. During May, 1928, there was an adjustment of the discount rate allowed upon the paper account, which represented a saving to the Association of some £350 during 1928.

The financial arrangements in connexion with the retirement of the late Sir Dawson Williams are set out in the account.

Composing, Machining, etc.—The number of pages increased from 6,060 in 1927 to 6,268 in 1928, and the number of JOURNALS printed increased from 1,907,806 in 1927 to 1,967,888 in 1928.

The amount required from Subscription Account for 1928 to cover the cost of production and issue of the JOURNAL was £12,047, or 7s. per Member. The amount required for 1927 was £13,718, or 8s. 2d. per Member, and during 1925 and 1926 the figure per Member was 8s. 4d.

ABSTRACTS H AND I.

30. Full details of the Income and Expenditure of those special journals published by the Association are here set out.

TRUST FUNDS.

31. *Office Staff Superannuation Fund.*—The market value of the stocks owned by this Fund on the 31st December, 1928, was £24,072 3s. 4d. A sum of over £800 (including Income Tax) has been repaid to retiring members of the Fund who have left the service of the Association.

Charities Fund.—The effect of the more active intervention of the Association in collections for the Medical Charities is now being seen, but progress is not rapid.

APPORTIONMENT OF MEMBERS' SUBSCRIPTIONS.

32. The Membership of the Association at the end of 1928 was 34,558. It must be remembered, however, that all Members do not pay the same rate of subscription; therefore, the average amount of revenue per member is less than the standard subscription of £3 3s.

The total revenue from subscriptions (excluding arrears) was £82,809, or roughly, £2 7s. 11d. per member.

The following table has been calculated on this basis to show how the subscription of a member was apportionable towards defraying the expenses of the Association for the year ending 31st December, 1928.

	1928. £	1927. £ s. d.
Central Meeting Expenses	8,605	5 0
General Association Expenses	6,862	4 0
Central Staff Expenses	18,565	10 9
Central Premises Expenses	10,117	5 10
Central Printing, Stationery, and Postage Expenses	2,938	1 8
Library Account Expenses	996	7
Journal Account Expenses	12,047	7 0
Irish Committee Expenses	1,081	8
Scottish Committee Expenses	2,138	1 3
Capitation Grants to Branches	6,856	4 0
Subscriptions written off	3,770	2 2
Depreciation	4,420	2 6
Sundry Publications	144	1
Part Transfer to Sinking Fund, Reserves, etc.,	4,270	2 5
	82,809	£2 7 11

	1927. £ s. d.
Central Meeting Expenses	5 0
General Association Expenses	3 7
Central Staff Expenses	10 10
Central Premises Expenses	6 0
Central Printing, Stationery, and Postage Expenses	1 7
Library Account Expenses	7
Journal Account Expenses	8 2
Irish Committee Expenses	8
Scottish Committee Expenses	1 3
Capitation Grants to Branches	4 1
Subscriptions written off	2 2
Depreciation	2 6
Sundry Publications	1
Part Transfer to Sinking Fund, Reserves, etc.,	10
	£2 7 4

Estimate of Receipts and Expenditure during 1929.

Receipts.

	1928. Actual. £	£		1929. Estimated. £
Subscriptions	85,112	2,388	Increase	87,500
Advertisements	51,782	1,218	Increase	53,000
Sale of *Journals*, etc.	8,663	163	Decrease	8,500
Investments and Rents	5,759	1,241	Increase	7,000
Sundries	53	53	Decrease	—
	£151,369			£156,000

Expenditure.

	1928. Actual. £	£		1929. Estimated. £
Central Meeting Expenses	8,605	5	Decrease	8,600
General Association Expenses	6,862	2,138	Increase	9,000
Central Staff Expenses	18,565	435	Increase	19,000
Central Premises Expenses	10,117	883	Increase	11,000
Central Printing, Stationery, and Postage Expenses	2,938	262	Increase	3,200
Library Account Expenses	996	154	Increase	1,150
Journal Account Expenses	72,492	2,508	Increase	75,000
Irish Committee Expenses	1,081	49	Increase	1,130
Scottish Committee Expenses	2,138	12	Increase	2,150
Capitation Grants to Branches	6,856	344	Increase	7,200
Subscriptions written off	3,770	230	Increase	4,000
Depreciation	4,420	220	Decrease	4,200
Sundry Publications	144	6	Increase	150
Sinking Fund	1,142	—	—	1,142
Reserve Fund	5,000	2,500	Decrease	2,500
Dilapidations	1,500	—	—	1,500
Architect's Fees, etc.	4,756	59	Increase	4,815
Sundries	254	254	Decrease	—
	£151,636			155,737
Estimated Surplus				263
				£156,000

Organisation.

Membership Figures.

33. In 1928 there was a net increase in the membership of the Association of over 900, and the present membership represents a net increase of 14,500 since the War. The Council welcomes this recognition by the profession of the value of the work of the Association. The most fruitful sources of recruitment in the year were: central activities, 1,469; by oversea Branches, 550; by home Divisions and Branches, 353.

The following is a summary of the changes in the membership during 1928 (the figures for 1927 are shown for comparison):—

1927.			1928.		
New members	2,578		New members	2,289	
Paid arrears	1,067		Paid arrears	1,067	
Resignations withdrawn	33	3,678	Resignations withdrawn	46	3,402
Resignations	566		Resignations	604	
Deaths	351		Deaths	377	
Arrears	1,485		Arrears	1,485	
Expelled	1		Expelled	2	
			Erased under Article 9(c) (ii)	1	
		2,403			2,469
Increase		1,275	Increase		933
Membership December 31st, 1927		33,625			
Membership December 31st, 1928		34,558			

The numbers of new registrations (British Isles) in 1927 and 1928 were 1,700 and 1,482 respectively.

Work Done by the Divisions, Branches and Federal Committees.

34. The great majority of the Divisions and Branches in the British Isles, and many of the Oversea bodies, have already reported for 1928, and these reports, and the reports of proceedings published in the *B.M.J.* Supplement show gratifying activity on the part of most of the local units of the Association. During recent years there has been a remarkable increase in the local activities, especially from the point of view of scientific and clinical meetings, in respect of which the Council proposes to submit a more detailed statement in its supplementary report. On behalf of the Association, the Council desires to thank the Chairmen, Presidents, Secretaries, Treasurers and Executives of the Divisions, Branches and Federal Committees for the highly creditable work being done.

Association Organisation in Hertfordshire.

35. The organisation of the Association in Hertfordshire has for some considerable time been unsatisfactory. Up to January, 1929, there were two Divisions covering the area of the county, namely, the East Hertfordshire Division of the Cambridge and Huntingdon Branch, and the West Hertfordshire Division of the Metropolitan Counties Branch. With a view to improving Association organisation in the county, the Council, in December, 1928, convened a meeting of the members of the Association resident there, when the whole question was discussed. As a result of this meeting a Hertfordshire Branch has been formed of area coterminous with the county, with Barnet, East Hertfordshire, St. Albans and Watford Divisions. It is believed that the new Branch and its Divisions will satisfactorily solve what has been a difficult problem, and the Council offers its good wishes to the new units.

Final-Year Students and Newly Qualified Practitioners.

36. All those Divisions and Branches whose areas contain medical schools have taken successful action in connection with the scheme inaugurated by the Council for interesting final year medical students and newly qualified practitioners in the work of the Association. One result of these gratifying activities is seen in the increased membership of the Association among the newly qualified. Thus, of those who qualified during the year October, 1926, to September, 1927, 50 per cent. had already, at the latter date, joined the Association; and of the 2,429 practitioners who registered in 1922, only 863 were, at the end of September last, still outside the Association.

The Council has reviewed the question of the Prize Essay Competitions instituted in 1922 for the purpose of interesting final-year medical students in the work of the Association, and has decided, in respect of the 1929-30 competitions, that in addition to the final-year medical students (as at present), the newly qualified of not more than one year's standing shall be eligible to enter. A prize of £25 will be open for award in each of the six groups of medical schools. The subject for the essays is "Three cases illustrative of the value of ante-natal observation of pregnant women," and the essays must be received by January 11th, 1930.

Handbook for Recently Qualified Medical Practitioners.

37. The Association's Handbook for Recently Qualified Medical Practitioners continues to meet a real need, there being a steady demand for the book on the part of the newly qualified. Its section "Post-Graduation Study and Special Diplomas" is also found very useful by members contemplating or engaged in special post-graduate work. As the current (2nd) edition is likely to be exhausted in 1929, a new and revised edition of the book is being prepared. Copies of the 2nd edition of the Handbook can be had from the lending library, and the book is also on sale (3/6 post free) on application to the Financial Secretary of the Association.

Election of Representative Body, 1929-30.

Divisions in the British Isles.

38. The Council has, subject to one or two adjustments, repeated the 1928-9 grouping of the Divisions in the British Isles for election of the Representative Body, 1929-30. The complete list of constituencies will be found in the *B.M.J.* Supplement of April 13th, 1929.

Divisions outside the British Isles.

Each Division and Division-Branch outside the British Isles has, as is customary, been made an independent constituency.

ELECTION OF COUNCIL, 1929-30.

39. Pursuant to the standing authority conferred on it by the Representative Body, the Council has grouped the Branches and constituencies in the British Isles for election of the "24" and "12" members of the Council for 1929-30 in the same way as for 1928-9 (*see* Annual Handbook, page 49), except that the Surrey Branch has been transferred from Group M to Group L in the "24"-election, and the new Hertfordshire Branch has been added to Group E in the "24"-election and to Group III in the "12"-election. The Branches outside the British Isles have been grouped for election of the "7" members of Council, 1929-30, in the same way as for 1928-9 (*see* Annual Handbook, page 53).

DECISIONS OF THE ASSOCIATION.

40. The Council has under consideration questions as to the effect of decisions of the Association and the position of local units and members of the Association in relation thereto. The opinion of Counsel is being taken, and the Council will later report fully on the whole question.

Science.

SCIENTIFIC WORK OF ANNUAL MEETING, 1929.

41. The Council has arranged the following Sections for the forthcoming Annual Meeting at Manchester. *Three-day Sections:* Medicine, Surgery, Obstetrics and Gynæcology, Diseases of Children, Neurology and Psychological Medicine, Physiology and Bio-Chemistry. *Two-day Sections:* Pathology and Bacteriology, Oto-Rhino-Laryngology, Ophthalmology, Anæsthetics, Dermatology, Radiology and Radio-Therapeutics, Venereal Diseases, Orthopædics, Tuberculosis, Public Health, Occupational Diseases. *Single-day Sections:* History of Medicine, Medical Sociology.

THE ASSOCIATION'S SCHOLARS AND GRANTEES.

42. The sum granted by the Council for the direct encouragement of original investigation and research amounted to nearly £1,200 during the past year. The following awards were made:—

Ernest Hart Memorial Scholarship.

John Clifford Hoyle (Cambridge)	To investigate the association of the serum calcium level in tuberculous animals with calcium retention by the diseased organs, and with the acid-base balance of the blood.

Ordinary Research Scholarships.

Peel, Albert Arthur Fitzgerald (Glasgow)	Investigation of the morphology, cultural characteristics and variations of organisms belonging to a group intermediate between the bacteria and lower fungi.
Yoffey, Joseph Mendel (Manchester)	A histological re-investigation of mammalian lymphoid tissue.
Lloyd, Neville Langdon (London)	The rate of excretion of Novarsenobenzol and allied compounds in the urine and fæces.
Baird, Dugald (Glasgow)	Investigation of the bacteriology of infections of the urinary tract in pregnancy, with possible application to treatment.

Research Grants.

William S. C. Copeman (London), £100; J. H. Hannan (London), £25; Eric G. Holmes (Cambridge), £20; R. L. Mackay (Wolverhampton), £16; Elaine M. K. Salmond and Beatrice E. Turner (London), £40; Sylvia B. Wigoder and J. B. Gatenby Dublin), £40; Claude H. Whittle (Cambridge), £100.

Work of the Scholars and Grantees.

Several important results were obtained as a result of the work of the scholars and grantees for 1927-28, and numerous communications were made to the various scientific societies. A résumé of the work carried out was published in the *B.M.J.* Supplement of September 29th, 1928 (p. 143).

REMUNERATION OF NON-PROFESSORIAL MEDICAL TEACHERS, LABORATORY AND RESEARCH WORKERS.

43. The existing policy of the Association concerning the remuneration of non-professorial medical teachers, laboratory and research workers (in Grade I) which is as follows:—

"Grade I: Comprising those of Grade II (*i.e.*, laboratory or research workers or teachers who have had experience and are permanently and exclusively employed as such) whose qualifications or duties justify a position of seniority in status and a higher remuneration.

That the minimum salary for Grade I should be £750 per annum.

That after the probationary period (*i.e.* Grade III) has been completed, dismissal should be possible only on the grounds of neglect of duty, improper conduct or incapacity,"

is giving rise to some difficulty, inasmuch as it would appear that, once appointed to a post under the scale, a practitioner might assume that he has a right to expect a permanency, even though the reason for his engagement has ceased to exist. The Council suggests a modification of the last clause with a view to obviating this difficulty.

Recommendation: That the policy of the Association as regards the remuneration of non-professorial medical teachers, laboratory and research workers be amended to read as follows:—

Grade I: Comprising those of Grade II whose qualifications or duties justify a position of seniority in status and a higher remuneration.

That the minimum salary for Grade I should be £750 per annum.

That after the probationary period (*i.e.*, Grade III) has been completed, the tenure of any appointment should not be terminated without reasonable notice on either side, and dismissal should not be possible except in the case of neglect of duty or improper conduct.

THE LIBRARY.

44. Mr. Spencer Honeyman, who has been Librarian of the Association for 41 years, relinquished his appointment on March 31st, having reached the age for retirement. The Council has tendered the thanks of the Association to Mr. Honeyman for his long and faithful service and feels sure that members of the Association, and particularly those who have personally benefited by his advice and assistance, will join in wishing him health and happiness in his retirement.

Mr. T. J. Shields, formerly Senior Assistant Librarian to the Royal Society of Medicine, has been appointed to the vacancy, and on taking up his appointment the Council decided that supervision by an Honorary Librarian was not necessary.

Mr. Walter G. Spencer, F.R.C.S., who has acted in the capacity of Honorary Librarian to the Association since 1923, has rendered valuable services in connection with the Association's Library, and in particular during the strenuous period of the removal of the Library and its establishment in the new House, and the Council has placed on record its high appreciation of these services.

Increasing use continues to be made by members of the facilities provided by the Association's Library, both in the reading and lending departments. Since the Association occupied its new premises in Tavistock Square in 1925, the number of books borrowed yearly from the Library has increased from 7,206 to 12,732.

Notwithstanding this increase, however, it is evident that even now many members still do not appreciate the facilities which the Association's Library provides. These facilities have been greatly increased in recent years and members are recommended to make the utmost use of them.

In this connection attention is directed to the following Rule which was specially introduced to meet the needs of members outside London:—

"2. Application for any book to be sent post-free may be made in writing on a special postcard form. These forms may be obtained from the Librarian on the payment of 5s. 0d. for 12. Applications not on these forms must each be accompanied by a remittance of 6d. per volume towards the cost of postage and packing."

The upper part of the Hastings Hall will shortly be made available for use as the Library and Reading Room in place of the existing room. The Council believes that the new arrangements will greatly add to the amenities of the Association's Library. During the year a substantial addition has also been made to the storage accommodation which will permit of an early re-arrangement of the books in the Library.

LIBRARY CO-OPERATION.

45. As a practical step in the direction of Library co-ordination, the Association has joined the Central Students' Library. The function of this Library is to supplement the

supplies of books which any co-operating library can provide for students and to co-ordinate the various existing agencies, so as to put the individual student, wherever he lives and whatever be the subject of his study, in touch with the particular library, general or specialist, which has the books of which he is in need.

B.M.A. Lectures.

46. The system of B.M.A. Lectures to Divisions and Branches continues to be appreciated, and the Council in maintaining the provision of B.M.A. Lectures, urges Divisions and Branches to make the fullest possible use of these arrangements. The Council has also approved of Divisions and Branches paying out of Association funds in their possession the first-class railway fares of lecturers from a distance who are invited by the local units to give addresses at their clinical and scientific meetings. The Council believes that this arrangement should stimulate the scientific work of the local units, and a communication on the subject will shortly be addressed to them.

The following gave B.M.A. Lectures during the past year:—Dr. G. A. Allan, Dr. William Brown, Dr. W. Langdon Brown, Dr. H. C. Cameron, Dr. S. Cameron, Dr. Carey F. Coombs, Dr. E. P. Cumberbatch, Dr. A. H. Douthwaite, Mr. W. McAdam Eccles, Dr. W. Edgecombe, Dr. J. S. Fairbairn, Prof. John Fraser, Dr. A. R. Gow, Dr. C. B. Heald, Sir Thomas Horder, Dr. Gordon M. Holmes, Dr. A. F. Hurst, Dr. R. Hutchison, Prof. E. Mellanby, Dr. E. P. Poulton, Dr. Eric Pritchard, Sir James Purves-Stewart (2), Sir Percy Sargent, Mr. H. S. Souttar (2), Prof. C. W. Vining, Prof. D. P. D. Wilkie (2).

Treatment by Radiation and Electricity.

47. The Council has considered the question of the steps to be taken to give effect to the following Min. 55 of the A.R.M., 1928:—

> "Resolved: That the Representative Body express the following opinion, namely, that in view of the risks to the public involved in the use of electricity and radiation as methods of treatment by untrained and unqualified persons, it is to be desired (1) that suitable courses of training should be organised under medical direction for persons who wish to administer this form of treatment; (2) that persons who have satisfactorily followed such a course should be entitled to have their names entered on an approved Roll; (3) that one of the conditions attached to admission to, and maintenance on, the approved Roll should be abstention from the treatment of any patient except on the responsibility and under the general supervision of a registered medical practitioner; and (4) that patients who require electrical or radiation treatment should be referred only to those persons whose names are on the approved Roll."

The ideal solution is national legislation, which if it could be obtained, would afford complete protection to the public from a danger which clearly calls for early action. There is, however, no prospect of legislation being passed on the lines desired by the profession, and consequently no useful purpose would be served at present in pursuing this aspect of the matter. The solution by means of local regulation appearing to the Council to be equally unsatisfactory, the Council came to the conclusion that the only method which held out any immediate prospect of controlling treatment by radiation and electricity on the lines contemplated by the above Minute was by means of voluntary action, and that the most effective form of voluntary action would be the institution, by a recognised body, of a diploma denoting those lay persons who are qualified to act as dispensers of this treatment.

The Council approached the Society of Apothecaries in regard to the matter, and that body expressed itself as being generally in agreement with the objects which the Association had in mind. As a result, a scheme was prepared concerning (a) the establishment by the Society of Apothecaries of a Register of those qualified to dispense light treatment, and (b) the institution by the Society of a Diploma for the purpose of qualifying lay assistants in electro-therapeutics. Arrangements have been made to admit to the Register those who at present possess the necessary qualification for administering this treatment.

The scheme meets the four essential points laid down in the above Minute of the A.R.M. 1928, and active steps are now being taken by the Society to give effect to the arrangements. It is thus hoped that there will be in existence by January 1st, 1930, a Register, under the control of the Society of Apothecaries, of those qualified to dispense light treatment. It will then be of the utmost importance that practitioners should strongly advise their patients to accept treatment only at the hands of persons on the Register who can be relied on to work in proper relationship to the medical profession.

Collective Investigations into the Treatment of Varicose Ulceration and the After-History of Gastro-Enterostomy.

48. The Annual Representative Meeting at Edinburgh approved the proposals of the Council for conducting collective investigations into the treatment of varicose ulceration and the after-history of gastro-enterostomy, both of which investigations had the cordial approval of the Minister of Health.

The investigation into the treatment of varicose ulceration was conducted through the Divisions of the Association; thus, each Division in Great Britain and Ireland was asked to obtain the names of some of its members who were willing to complete the questionnaires. A considerable number of Divisions took an active part in this matter, as a result of which completed forms were received from 550 practitioners throughout the country.

The whole of the information thus received was collated by Dr. Arthur P. Luff, F.R.C.P., who has been appointed by the Council as Honorary Director of the Researches, and Dr. Luff's report, which was admittedly a practical contribution to the subject, was published in the *British Medical Journal* of December 22nd, 1928 (page 1144).

In carrying out the investigation, the Council was convinced that the united experience of doctors engaged in a properly conducted collective investigation ought to yield data of clinical value, and the report presented by Dr. Luff has confirmed this view. Arrangements for investigations into other subjects are now under consideration. The Council recognises that Dr. Luff's work in collating and presenting the information contributed in a high degree to the success of the investigation, and it has cordially thanked him for his services. The Council also desires to thank those members of the profession who so kindly completed the questionnaires.

The enquiry into the after-history of gastro-enterostomy is being proceeded with and the Council hopes to present a report at no distant date.

Katherine Bishop Harman Prize.

49. The Council is prepared to consider an award of the Katherine Bishop Harman Prize in the year 1930. The Prize will take the form of a Certificate and a cheque for £80.

The purpose of the Prize is the encouragement of study and research directed to the diminution and avoidance of the risks to health and life that are apt to arise in pregnancy and child-bearing. Competitors are left free to select the work they wish to present, provided the work falls within the scope of the Prize. Any medical practitioner registered in the British Empire is eligible to compete for the Prize.

Essays must be forwarded so as to reach the Medical Secretary not later than December 31st, 1929.

The Sir Charles Hastings Clinical Prize.

50. The Sir Charles Hastings Clinical Prize, consisting of a Certificate and a cheque for 50 guineas, which was established by the Council for the promotion of systematic observation, research, and record in general practice, has been awarded in respect of the year 1929 to Dr. Arthur Crook (Norwich), for his clinical study entitled "Albumen in the urine in association with pregnancy and childbirth." This study, based upon the experience of 30 years in general practice, was adjudged to be deserving of high commendation. The Examiners were of opinion that it showed evidence of good work of the kind for which the Prize was designed.

Certificates of Honourable Mention have been awarded to Dr. William Edwards (Southborough) and Mr. Griffith Evans F.R.C.S. (Carnarvon).

Hempson Prize.

51. Mr. W. E. Hempson kindly placed at the disposal of the Association upon the occasion of his retirement from the position of solicitor to the Association, a sum of 25 guineas to be awarded for the best essay or treatise on some phase or branch of public health work. The subject selected for the competition was "A study of personal experiences in the inspection and treatment of school children under the auspices of any elementary education authority." The Council has awarded the Prize to Dr. A. C. T. Perkins (Bury St. Edmunds) for the study submitted by him on "The problems presented by school preventive medicine in rural areas." The points brought forward by this competitor in his essay were of practical importance; indeed it appears that certain practical steps on the lines suggested in this essay are at present under contemplation by the authorities.

Middlemore Prize.

52. The Council has decided to award the Middlemore Prize to Mr. W. S. Duke-Elder, F.R.C.S. (London). The following subject was selected for the competition:—

"The clinical study of the vitreous body, its swellings, contractions, opacities, and reactions to toxic invasion; with special reference to glaucoma and detached retina."

The essay submitted by Mr. Duke-Elder was declared by the Examiners to be "a manful attack on one of the most difficult problems of ophthalmology."

EXAMINERS IN ESSAY COMPETITIONS.

53. The Council has expressed its cordial thanks to the following gentlemen who acted as Examiners in the undermentioned competitions: Sir Humphry Rolleston and Prof. W. E. Dixon. (Sir Charles Hastings Prize); Mr. Vernon Cargill and Mr. E. E. Maddox (Middlemore Prize); Dr. R. H. Crowley and Prof. W. W. Jame on (Hempson Prize); Sir E. Farquhar Buzzard, Prof. A. J. Hall, Sir T. Horder, Dr. J. C. Matthews (Final-year Students' Essay Competitions).

Medical Ethics.

INSTITUTIONS FOR THE TREATMENT OF PATIENTS BY PHYSIO-THERAPEUTIC AND ELECTRICAL METHODS.

54. In view of the fact that an increasing number of institutions are being established for the treatment of patients by physio-therapeutic and electrical methods, the Council has considered the question of the conditions under which members of the profession should associate themselves with these institutions. So far as the question of advertising these bodies in the lay press is concerned, the Council adheres to the statements it made to the A.R.M. 1924 in its report on the subject of advertising of nursing homes and kindred institutions, namely:—

(i) The General Medical Council and the profession generally have acquiesced in the custom, now of long standing, of advertising in the lay press, nursing homes, sanatoria and hydropathic institutions, and it (the Council) feels that, in any policy formulated by the Association, regard must be had to this custom; and

(ii) That the practice of advertising these institutions in the lay press is one which should not be extended.

The Council is, however, of opinion that in practice a distinction can be made between the class of institutions the advertisements of which are at present accepted by the *British Medical Journal* although they are advertised in the lay press, and other institutions or organisations founded on a commercial basis for the treatment of patients by physio-therapeutic and electrical methods.

The Council recommends:—

Recommendation: That the R.B. reaffirms the opinion it expressed in 1924 that the General Medical Council and the profession generally have acquiesced in the custom, now of long standing, of advertising in the lay press, nursing homes, sanatoria and hydropathic institutions, and feels that, in any policy formulated by the Association, regard must be had to this custom; and further that the R.B. takes no exception to the assocation of registered medical practitioners with an institution for the treatment of patients by physio-therapeutic and electrical methods, provided the following essential conditions are strictly conformed to:—

(a) That the institution is not in any way advertised to the lay public.

(b) That the treatment of all patients is under the direct control of a registered medical practitioner who accepts full responsibility for their treatment.

(c) That the relation between the medical officer of the institution and private practitioners conforms to the usual ethical procedure between consultant and private practitioner.

MEMBERSHIP AND ACCEPTANCE OF POST WHICH IS THE SUBJECT OF AN IMPORTANT NOTICE.

55. The Council has sympathetically considered the following Minute 60 of the A.R.M. 1928 which was referred to it:—

Proposed by North Middlesex: That no medical practitioner shall be eligible for membership of the Association who has obtained and holds a position the terms of which are contrary to the declared policy of the Association,

and has had special regard to what was intended by North Middlesex in submitting the motion rather than to the precise phraseology of the motion itself. Thus, the Council considered whether the object in view could not be better secured by some other but similar proposal.

As things stand, under Article 3 any medical practitioner registered in Great Britain or Ireland under the Medical Acts is eligible as an ordinary member of the Association, and no conditions are or have been prescribed other than those laid down in By-law 4 to the effect that, if elected, a candidate will pay his subscription to the Association and will abide by the Regulations and By-laws and the rules of the Division or Branch to which he may at any time belong.

Leaving out candidates not resident in the area of any Branch, and Service candidates, the election of members in Great Britain and Ireland (By-law 5) is vested in the Council of the Branch in the area of which the applicant resides.

The election of candidates to membership of the Association is unquestionably one of the most important functions of Branch Councils, and these bodies have complete freedom as regards election or non-election of candidates residing within their areas. The Council is of opinion that the responsibility of Branch Councils in this respect should in no way be weakened. It should be the duty of each Branch Council to scrutinise carefully the credentials of every applicant for election, trusting to the special local knowledge of the Divisions, all of which are represented on the Branch Council. It is desirable that the Secretary of the Branch should from time to time draw the attention of Divisional representatives on the Branch Council to their special responsibility in regard to candidates residing in their respective areas. Approximately 1,500 candidates are elected annually by the Branch Councils in Great Britain and Ireland, and with rare exceptions the Branch Councils discharge their elective functions in an eminently satisfactory manner. If a candidate for a post or holder of a post the terms of which are contrary to the declared policy of the Association applies for membership of the Association, the Branch Council which deals with the application will doubtless give due weight to this fact. The proposal of North Middlesex would curtail the existing powers of Branch Councils, and what is even more serious would lessen their sense of responsibility when considering each application.

Another objection to the proposal is that, as limited, the penalty of exclusion would fall solely upon a candidate for election who had been appointed to a banned post, while there would be no definite exclusion of candidates who had applied for the same appointment, though unsuccessfully. Presumably the circumstances of such candidates would be considered, but in the nature of the case any restriction should apply to unsuccessful as well as to successful candidates for barred appointments and equally to any blemishes on the past ethical history of candidates.

The Council is therefore of opinion that the adoption of the North Middlesex proposal would be a mistake.

APPLICATION TO SCOTLAND AND NORTHERN IRELAND OF THE SCALE OF MINIMUM COMMENCING SALARIES FOR WHOLE-TIME PUBLIC HEALTH APPOINTMENTS.

56. Following upon the adoption by the A.R.M. 1928 of a scale of minimum commencing salaries for whole-time public health appointments in Scotland, the Council has urged the Divisions and Branches in Scotland to adopt binding resolution under their Ethical Rules in connection with these appointments. A number of units have now taken action in this connection, and it is hoped that the remainder will without delay attend to this important duty.

The Ulster Branch has adopted an appropriate resolution under its Ethical Rules concerning whole-time public health appointments in Northern Ireland.

THE ETHICAL WORK OF THE ASSOCIATION.

57. A great amount of the work of the Central Ethical Committee and of its Standing Sub-Committee concerns matters which cannot be made the subject of detailed report. Advice is frequently sought on matters of ethics and disputes between members of the profession. The Central Ethical Committee, acting for the Council, has adjudicated in several disputes between members where a satisfactory settlement would not have been possible without bringing the parties together at a hearing. Increasing experience shows that the advice on ethical matters which the Association is able to give through its central office and by its Ethical Committees, both local and central, is much appreciated by members.

ETHICAL RULES.

58. In pursuance of the standing instruction of the Representative Body the Council reports that the following bodies in Great Britain have not yet adopted the revised Ethical Rules:—*Divisions*: Argyllshire, Dumbartonshire, Durham, Edinburgh and Leith, Folkestone, Hal[illegible], Salford. *Branch*: Edinburgh.

Medico-Political.

CENTRAL EMERGENCY FUND.

59. This Fund was created in 1905 with the object of assisting members of the Association to maintain the interests of the profession where necessary, against organised bodies by grants which cannot be made out of the funds of the Association. The Fund is administered by the members of the Medico-Political Committee, who act as trustees, and is entirely supported by voluntary contributions.

Grants are given, after careful inquiry, to doctors who have suffered financial loss as a result of supporting the policy of the Association. Though recently no demands have been made on the Fund claims may arise at any time and past experience shows that it is a most useful weapon to have in reserve. The Council therefore recommends it to the support of members.

DANGEROUS DRUGS ACTS AND REGULATIONS.

60. At a conference held at Geneva in 1925 a Convention was signed on behalf of this country for the purpose of completing and strengthening the provisions of the International Opium Convention signed at the Hague in 1912. To give effect to this Geneva Convention the Dangerous Drugs Act of 1925 was passed which provided for:—

(1) the extension of Part I of the 1920 Act to include coca leaves, Indian hemp and resins obtained from Indian hemp, as well as raw opium;

(2) the amendment of Part III of the 1920 Act so that any substance containing *any* proportion of diacetylmorphine (heroin) should be included in the list of controlled drugs instead of those substances containing not less than one-tenth per cent. of diacetylmorphine and also included extract or tincture of Indian hemp.

Strong representations were made by the B.M.A. to the Home Office objecting to the new provision in regard to heroin, but without effect. There was no general demand by members of the B.M.A. for any further action which, as it would have been against an international agreement, in the nature of the case would have been useless unless it could be shown that there was an exceedingly strong opposition. The Act provided that it should come into operation only on such date as His Majesty might by Order in Council appoint. On the 25th September, 1928, the Act was put into operation. Protests immediately began to come from members. Attempts were again made but without avail to secure either the exclusion of substances containing less than one-tenth per cent. of heroin or the exemption of such substances containing heroin as because of their nauseating qualities could not be used for the purposes of addiction. The Dangerous Drugs (Consolidated) Regulations, 1928 (dated December 14th, 1928), came into force on 1st January, 1929.

It would appear that the only way to secure the exemption of any preparation containing any of the narcotic drugs to which the Dangerous Drugs Acts now apply and which it is contended cannot give rise to the drug habit on account of the medicaments with which the said drugs are compounded and which in practice preclude the recovery of the said drugs, is by approaching the Health Committee of the League of Nations which after submitting the question for advice and report to the Permanent Committee of the Office International d'Hygiene Publique in Paris may find this to be so and communicate its finding to the Council of the League of Nations which Council will then communicate the finding to the parties to the Convention following which the provisions of the Convention will not be applicable to the preparations concerned. The Council is still in correspondence with the Home Office on this subject.

ELECTION OF DIRECT REPRESENTATIVES FOR ENGLAND ON G.M.C., 1928.

61. The Council is glad to be able to report that the Association's two nominees for election as Direct Representatives for England on the General Medical Council (namely, Drs. J. W. Bone and E. K. Le Fleming), in October, 1928, were handsomely returned at the head of the poll.

ELECTION OF DIRECT REPRESENTATIVES FOR ENGLAND ON G.M.C., NOVEMBER, 1929.

62. There will be two vacancies this year among the Direct Representatives for England on the General Medical Council caused by the completion of five years' service as Direct Representatives of Dr. H. B. Brackenbury and Sir Jenner Verrall, who were two of the candidates selected for support by the Association in 1924. Both candidates are eligible for re-election. The Council has decided to adopt the procedure already approved by the Association in connection with the October, 1928, election for the November, 1929, election except that instead of holding a meeting of English and Welsh Representatives at the A.R.M., the selection of candidates shall be decided by a voting paper issued during that meeting to the English and Welsh Representatives. The meeting served no useful purpose and the poll by voting papers will save the time of the Representative Body.

POOR PERSONS' PROCEDURE.

63. The Council has co-operated with the Law Society in securing free medical services in the provinces (examination and evidence) in nullity cases (Poor Persons' Procedure) in which cases solicitors and barristers also give their services gratuitously. The Law Society has thanked the Association for its action, and the Council of the Society expressed its appreciation in its last Annual Report of the help which was given.

PRESERVATION OF INFANT LIFE BILL (H.L.).

64. While the existing legislation provides penalties for criminal abortion and for the destruction of an infant life after birth, no penalties are provided where the infant life is destroyed while the child is being born, a position which the Association has always considered should be remedied.

The above-mentioned Bill introduced in the House of Lords had for its object the remedying of this state of affairs but, unfortunately, it placed on the medical practitioner the onus of proof that the act which caused the death of the child in process of being born had been done in good faith and only for the purpose of preserving the life of the mother. During the progress of the Bill, however, the wording of the relevant clause (Clause 1 (1)) was amended in such a way as to transfer to the complainant the onus of proof, viz., that the destruction of the life had not been done in good faith and only for the purpose of preserving the life of the mother, an amendment which the Council is of opinion adequately safeguards the position of the medical practitioner.

Clause 1 (1) as sent from the House of Lords to the House of Commons reads as follows:—

1.—(1) Subject as hereinafter in this sub-section provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existance independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life:

Provided that no person shall be guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

The Council recommends:—

Recommendation: That Clause 1 (1) of the Preservation of Infant Life Bill (as amended) be approved.

MEDICAL PRACTITIONERS AND ROAD ACCIDENTS.

65. The Council has considered the following resolution of the A.R.M., 1928:—

Minute 133.—Resolved: That the Representative Body instructs the Council to consider whether some arrangement could be made for payment for the emergency services rendered by doctors to patients meeting with accidents on the roads;

and the following proposals submitted by the Representative of the Bucks. Division who proposed the motion in the A.R.M., namely—that there should be some form of insurance which would pay for first-aid, whether given by private practitioners or by hospitals, and as road accidents are practically always due to motors, the payment might be made either from the driving or motor licence funds or by some form of compulsory insurance against third party risks.

The Council is of opinion and recommends accordingly:—

Recommendation: That the Representative Body is of opinion that failing the creation of a central fund by some extra tax on motorists or some system of compulsory insurance, including a priority for charges for medical attendance on any claims made, either of which methods would require legislation, probably highly contentious in nature, no satisfactory solution can be devised of the difficulty experienced by doctors in recovering the amount of their charges for treatment rendered to patients meeting with accidents on the road; further, the Representative Body is of opinion that no greater case can be made out for dealing specially with the non-payment of fees incurred by persons involved in road accidents, than for those incurred in the treatment of the victims of any other form of accident.

ROAD VEHICLES' REGULATION BILL.

66. The Road Vehicles' Regulation Bill, *inter alia*, seeks to empower the Minister of Transport to make Regulations requiring that a licence to drive a mechanically propelled vehicle shall not be issued or renewed until the person concerned has satisfied the licensing authority, either by production of a certificate by a registered medical practitioner after examination by him of the applicant, or otherwise, that he is physically fit to drive such a vehicle. This subject has been carefully considered in the light of evidence of what has already been attempted in some other countries collected by the Association Professionnelle Internationale des Médecins.

The Council recommends:—

Recommendation : That although it is unsatisfactory that fitness for driving a mechanically propelled vehicle should, as at present it is, be ignored entirely in the granting of a driving licence, the practical difficulties in regard to the position, including that of obtaining a consensus of opinion as to what the disabilities should be, are such that it is inadvisable for the Association at present to make a pronouncement in the matter; further, that no scheme in this respect so far proposed is free from great practical difficulties.

EVIDENCE SUBMITTED BY THE ASSOCIATION TO THE DEPARTMENTAL COMMITTEE ON THE TRAINING AND EMPLOYMENT OF MIDWIVES.

67. The Minister of Health in May, 1928, appointed a Committee "to consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of medical students in midwifery), and the conditions under which midwives are employed." The personnel of the Departmental Committee is Sir Robert Bolam, Dr. J. W. Bone (nominee of B.M.A.), Dame Janet M. Campbell, Lady Cynthia Colville, Dr. W. A. Daley, Dr. J. S. Fairbairn, Dr. T. Eustace Hill, Miss Alice Gregory, Mr. A. B. Maclachlan, Dr. F. N. Kay Menzies, Mrs. Bruce Richmond and Miss Stephenson.

A memorandum of evidence was submitted on behalf of the Association to the Departmental Committee (*see* Appendix IV) and from paras. 18 and 19 and para. 27 thereof it will be seen how the following Minutes 99 and 102 of the A.R.M., 1928, have been dealt with:—

Minute 99.—Resolved: That in para. 40 of the Report (on the Causation of Puerperal Morbidity and Mortality) the following be inserted . . . "that such immediate steps be taken as will ensure full and cordial co-operation between doctor and midwife."

Minute 102.—Resolved: That the following recommendation contained in para. 40 of the Report (on the Causation of Puerperal Morbidity and Mortality) be adopted:—

(4) That a condition of the payment of maternity benefit under the National Health Insurance Acts should be that the mother has had at least one ante-natal examination by a qualified medical practitioner during her pregnancy.

Oral evidence in support of the memorandum was given on 30th January, 1929, by Drs. H. B. Brackenbury, C. E. S. Flemming, Christine M. Murrell, William Paterson and the Medical Secretary.

67 (a). In connection with paras. 23-7 of the Memorandum of Evidence a special Sub-Committee of the Medico-Political and Insurance Acts Committees has been appointed to formulate a scheme for ante-natal supervision and attendance at the confinement and during the puerperal period. This will be the subject of later report.

ASSISTANT MEDICAL OFFICERS TO MENTAL HOSPITALS.

68. The terms and conditions of employment of assistant medical officers to mental hospitals was the subject matter of a series of recommendations to the A.R.M. at Cardiff in substitution for the policy of the Association adopted as long ago as 1915. The A.R.M. at Cardiff gave general approval to the recommendations submitted by the Council and rescinded the 1915 policy, but decided that the recommendations should not be made part of the policy of the Association until there had been further opportunity for negotiation between the Association and the bodies concerned with the appointment of assistant medical officers to mental hospitals.

The whole matter has been referred to the Conference of representatives of the Association and Society of Medical Officers of Health with representatives of Local Authorities Associations (including the Mental Hospitals Association) which is now sitting under the Chairmanship of Lord Askwith with reference to the scale of minimum commencing salaries for whole-time public health medical officers.

RATING ASSESSMENT OF A DOCTOR'S HOUSE.

69. The question of the rateable value of a doctor's house having been raised by a member whose assessment has been increased on the ground that his house is used partly for professional purposes, and this being a matter affecting the profession generally, the Solicitor of the Association has been authorised to deal with the matter, if necessary, by appeal to Quarter Sessions.

CONTRACT RATES FOR JUVENILE ODDFELLOWS.

70. The Council has considered the following Minute of the A.R.M., 1928:—

Minute 95.—The following motion was carried (81 for, 63 against) and the Chairman declared that as this was not a two-thirds majority in favour of the motion it did not become a decision of the Association in accordance with Article 33 (i):—

That the Representative Body approve a standard rate of 8s. 8d. per head per year, including drugs, for the remuneration of medical practitioners for medical attendance and medicine for juvenile members of the Manchester Unity of the Independent Order of Oddfellows; that the Council be authorised to approve a slightly lower rate than 8s. 8d. per head per year for a time to be definitely stated, for application in any area in which it is satisfied that owing to economic conditions the standard rate of payment is not feasible; and that it be an essential part of this arrangement that there must be free choice of doctor by patient and of patient by doctor,

and the position created by the fact that the motion although carried by a majority, was not passed by a two-thirds majority and therefore did not become the policy of the Association.

The Council is of opinion that while the position thus created precludes the Association from making a national arrangement for the treatment of juvenile oddfellows at 8s. 8d. per head per year, it permits the Divisions and Branches of the Association to make local arrangements on the lines suggested in Minute 95 of the A.R.M., 1928, without contravening the policy of the Association.

HEALTH OF MERCHANT SEAMEN.

71. The Council has under consideration the question of the health of merchant seamen and the desirability of urging the Government to introduce a proper medical and sanitation service in the mercantile marine. The matter is of considerable importance as the International Labour Office of the League of Nations is considering it and it may be necessary to place the opinions of the Association before that body.

An Inter-Departmental Committee has been set up by the Board of Trade and Ministry of Health to advise the two Departments on matters of common interest affecting the health of merchant seamen, and the preparation of a report on the health of the mercantile marine will be one of the first questions which the Committee will consider.

The Council has informed the Committee that it has set up a special Sub-Committee to consider matters connected with the health of merchant seamen and that it hopes that the Departmental Committee will be able to see its way to recommend that the responsibility for the health of the merchant seaman should be undertaken by the Ministry of Health in accordance with the policy of the Association that all services relating to the health of the community should be co-ordinated under the Ministry, and that the first step should be to place the collection and analysis of statistics of mortality and sickness amongst seamen in the hands of the Ministry of Health.

PARLIAMENTARY GENERAL ELECTION, 1929.

72. In accordance with the general instructions contained in Minutes 260-5 of the A.R.M., 1906, candidates for the Parliamentary General Election, 1929, as on previous occasions, are being approached through the Divisions of the Association in order that they may be made aware of the Association's views on matters affecting the public health and the medical profession.

Past experience has shown that it is not advisable to try to obtain definite pledges from Parliamentry Candidates, in fact many candidates strongly resent the attempted extraction of such pledges on subjects which they have never heard debated and on which they cannot honestly express any opinion. The Council feels that there will be a much better chance of getting candidates to consider matters put before them by the Association if they are approached before they are actually immersed in an election campaign

and it has therefore been decided to approach all prospective candidates as early as possible in the hope that by so doing they will have more time in which to consider the information put before them on the following subjects (1) National Health Insurance, (2) Remuneration of women medical practitioners, (3) Voluntary Hospital System, (4) Vaccination and Vivisection, (5) State registration of unqualified practitioners.

MATERNAL MORTALITY ENQUIRY.

73. The Council reported to the A.R.M., 1928 (*see* paragraph 174 of the Annual Report) with regard to the suggested investigations into maternal deaths, that such investigation would be useful (a) if carefully controlled by competent experienced medical officers, (b) if the results were used exclusively for scientific purposes, and (c) if where necessary such investigations were followed by the offer of expert advice and assistance, institutional or otherwise; further that, having received a satisfactory assurance from the Ministry of Health, it had urged upon members of the profession that they should render assistance by helping to make the investigations as complete and accurate as possible.

The Ministry of Health later set up a special Committee to consider the method of these investigations and to draw up a form of report which would elicit the required information. The form of report was submitted to the Council in draft, and certain minor modifications were suggested therein by the Council which have now been agreed by the Ministry. The whole of the procedure in regard to the legal position of these reports once they have been completed, and their final destination, has been most carefully gone into in consultation with the Ministry of Health, and the Council feels satisfied that the procedure now adopted safeguards the position of practitioners who give information in regard to cases they have had under their care. The Council therefore urges practitioners to do all they can to forward an effort which, if successful, will do something to bring about a reduction in the rate of puerperal mortality.

The Association has been asked what fee a medical practitioner should charge for his part in completing these enquiry forms. The Council is of opinion that as this is part of a serious national effort to ascertain the cause of and, if possible, to lessen maternal morbidity and mortality, it would be a gracious action on the part of the profession if they gave their help without fee, particularly as the service is one which will not be required at all from many practitioners or frequently from any of them. The Council considers that the Association should make a pronouncement on the matter and recommends:—

Recommendation: That, as the giving of information to the medical investigator who will fill up the form of enquiry into maternal mortality issued by the Departmental Committee on Maternal Mortality is regarded by the Association as a voluntary contribution on the part of the medical profession to a scientific enquiry on a question of pressing public importance, the Association is of opinion that no fee should be charged for the service and none accepted if offered.

POSITION OF DOCTORS CONDUCTING SPECIAL TREATMENTS.

74. The London County Council General Powers Act, 1920, and the Manchester Corporation Act, 1924, have made compulsory registration of establishments where special treatment (*e.g.*, massage, electrical, etc.,) is conducted. Very little trouble has arisen in London owing no doubt to the difficulty of inspecting all doctors' premises to find out what they are doing, but the Manchester Corporation proposed to require every doctor who did any light treatment to register. The Association's Solicitors were of opinion that the interpretation put upon the expression "establishments for massage and special treatment" by the Manchester Corporation was too wide and could not be held to include the house of a doctor who occasionally gave ultra-violet or electrical treatment.

The Manchester Division Secretary was supplied with a copy of the Solicitors' Opinion and after negotiation with the Watch Committee it was agreed "that unless a licensed registered medical practitioner sets up the necessary appliances for specific treatment, other than in the ordinary treatment of private patients, such premises would not be 'an establishment' within the meaning of the Act"—which statement is taken to mean that if a doctor sets up an establishment where he devotes himself specially to electrical or hydropathic, etc., treatment, to the exclusion of ordinary treatment, then only would he be expected to register.

In order to escape inspection under these Acts it is necessary for a doctor who habitually carries out special treatment to obtain a certificate signed by two other doctors that he is a fit and proper person to do so. To simplify the procedure for doctors in London the L.C.C. has agreed to accept the yearly certificate of the British Institute of Radiology or the Section of Electro-Therapeutics of the Royal Society of Medicine in respect of members of those bodies who desire to set up establishments to practise radiology, electrology and other forms of physiotherapy in the L.C.C. area.

NOISE IN RELATION TO HEALTH.

75. In connection with the following resolution, which was passed by the A.R.M., 1928:—

> *Minute* 165.—Resolved: (1) That in the interest of the public health the British Medical Association support any measures which may be taken so to alter or amend existing legislation as to give greater power to local authorities to suppress unnecessary noise which is disturbing to the lieges; and (2) that any noise from 11 p.m. to 6 a.m. which is capable of being prevented or mitigated, and which is dangerous or injurious to health, shall become a nuisance within the meaning of the Public Health Acts,

the Council prepared a memorandum published in the *British Medical Journal* of 10th November, 1928, which was submitted to the Minister of Health on 4th December, 1928, by means of a deputation consisting of the Chairman of the Representative Body, Chairman of Council, Treasurer, Chairman of the Medico-Political Committee, Sir Richard Luce, M.P., Drs. Dan MacKenzie and T. G. Nasmyth, with the Medical and Assistant Medical Secretaries. The Association's deputation coincided with an influential deputation from the People's League of Health. A full report of the deputation was published in the *B.M.J.* of 8th December, 1928, pp. 1,053-4, and the whole subject secured a great deal of publicity.

The Minister did not appear to be convinced that the matter was one which fell within his province, but said that it was more a matter for the Minister of Transport and the Home Secretary. He was apparently not satisfied that the Association had proved its case so far as the effect of noise on the health of the public was concerned, but indicated that its representations would receive careful consideration.

Public Health and Poor Law.

SCALE OF SALARIES FOR WHOLE-TIME MEDICAL OFFICERS IN POOR LAW HOSPITALS.

76. With reference to the following resolution of the A.R.M. 1928:—

> *Minute* 166.—Resolved: That it be an instruction to the Council to consider and, if necessary, to confer with local authorities and with members of the medical profession concerned and to submit to the Representative Body at its next meeting a scale of salaries for whole-time medical officers in poor law hospitals,

negotiations in connection with the scale of minimum commencing salaries for whole-time public health medical officers are proceeding between representatives of the British Medical Association and Society of Medical Officers of Health and representatives of the Local Authorities' Associations. These negotiations may have an important bearing on the salaries and status of medical officers to poor law hospitals who under the Local Government Act will come under the jurisdiction of the County and County Borough Councils. The Council hopes to be able to report fully in its Supplementary Report.

CO-OPERATION OF OTHER MEDICAL JOURNALS.

77. The Council on behalf of the Association places on record its deep appreciation of the cordial support given to the Association in its campaign for the improvement of salaries and conditions of employment of medical officers of health and their colleagues, by the proprietors of "The Lancet" and "The Medical Officer."

PUBLIC EDUCATION IN HEALTH.

78. The Council has unfortunately been unable to arrange for the usual Hastings Health Lecture to the public during this session owing to the building operations.

RISK OF ARBITRARY DISMISSAL OF OFFICERS BY LOCAL AUTHORITIES.

79. The Council has considered a case recently heard in the Courts wherein the clerk of a public authority sought to recover damages for alleged wrongful dismissal from his post of assistant

clerk and overseer (*see* Leading Article on p. 461 of *B.M.J.* of 9th March, 1929). The Judge in delivering judgement stated that the question was whether Section 189 of the Public Health Act, 1875, conferred on district councils a power of dismissal which could not be negatived or impaired by any contract of service, and he concluded that the authority could dismiss its clerk, at pleasure, whatever might be the contract, and further that no right of hearing before dismissal was given to that employee by Section 5 of the Local Government Act, 1894, or by any other Act, and the action therefore failed.

This case is of course very unusual and it is improbable that many responsible bodies would wish to take advantage of a position which apparently puts them above all ordinary contractual obligations. But the fact that such a case should occur is sufficient to cause consternation in the minds of those who are employed by public authorities.

The Council has asked the Society of Medical Officers of Health and the National Association of Local Government Officers to join the Association in efforts to secure that local authorities be made liable, like other bodies and persons, to honour contracts into which they enter with their officials.

Tuberculosis Officers and Loss of Office.

80. The Council has recently been consulted as regards a tuberculosis officer who in the course of his official duties contracted a disease which ultimately and permanently unfitted him for further employment. As the Council is advised that no legal claim can be made in such cases, all officials in the public health service and in institutions are strongly urged to cover this risk by insurance.

Repeated representations were made to the employing authority, both by the Division and by the Head Office, with a view to obtaining compensation for this officer, but the authority refused this application on the following grounds :—

(a) that the officer received full salary for a considerable time during which he was unfit to carry out his duties, which in effect amounted to compensation ; and

(b) that no definite proof could be advanced that he had been infected by the patient.

The Council considers this to be such an unusual repudiation of a strong moral claim that it is taking steps to bring the matter to the notice of the public through the press.

Co-operation with Society of Medical Officers of Health.

81. During the past session there have been several useful conferences between representatives of the Association and of the Society of Medical Officers of Health with regard to the question of co-operation between the two bodies and in relation to the application of the scale of minimum commencing salaries for whole-time public health appointments. The Council is also glad to note a growing disposition on the part of Divisions and Branches to secure the services of representatives of the public health service on Executive and other Committees and Branch Councils.

National Health Insurance.

Maternity Benefit.

82. The Council while in entire agreement with the following Minute 102 of the A.R.M., 1928, is of opinion that effect can only be given thereto by fresh legislation as to which there appears to be no likelihood in the immediate future :—

Minute 102.—Resolved : That the following recommendation contained in para. 40 of the Report be adopted :—

(4) That a condition of the payment of maternity benefit under the National Health Insurance Acts should be that the mother has had at least one antenatal examination by a qualified medical practitioner during her pregnancy.

The necessity for some such action has been strongly pressed on the Departmental Committee which is considering the Midwives Act and cognate subjects.

National Formulary.

83. The Insurance Acts Committee of the Association, in co-operation with the Ministry of Health and the Retail Pharmacists Union, has prepared and is issuing for the use of medical practitioners and pharmacists in connection with the provision of medical benefit under the National Health Insurance Acts a National Formulary, which it is hoped will come into operation eventually throughout the whole country to the great convenience of insurance practitioners and especially those who practise in more than one insurance area.

Additional Benefits.

84. The Insurance Acts Committee has appointed a special Sub-Committee to consider and report upon all questions connected with the extension of N.H.I. benefits which are of a consultant or specialist character. Representatives of the various Committees of the Association interested have been included among the personnel.

"Medical Insurance Practice."

85. The Council has taken over the publication known as "Medical Insurance Practice," by Messrs. R. W. Harris and L. Shoeten Sack, the new edition of which has now been published. This book is acknowledged to be the standard work of reference on this subject and its use, it is hoped, will be greatly facilitated by the fact that it is being published, with the support of the National Insurance Defence Trust, by the Association at cost price.

Medical Benefit Regulations.

86. The new Regulations concerning which discussion has been proceeding between the Insurance Acts Committee and the Ministry during the past eighteen months received their final form and came into operation as from December, 1928.

Excessive Sickness Benefit Claims—Medical Certification.

87. This matter is still under discussion between representatives of the Association, the Ministry of Health, and approved societies. A method of procedure in this connection has been incorporated in draft Regulations which will be submitted for the consideration of Panel Committees in the near future.

Scotland and National Health Insurance Practice.

88. In recent discussions between representatives of the Ministry of Health and the Insurance Acts Committee on matters affecting insurance practice common to the whole country it had been noted that no representatives of the Scottish Department of Health have been present, with the result that separate negotiations upon matters common to insurance practitioners as a whole have been made necessary between the Scottish Department of Health and the Scottish Sub-Committee of the Insurance Acts Committee. Being of opinion that this practice is disadvantageous to the profession and generally speaking uneconomical the Council urged the Ministry of Health to take steps to remedy this defect. Accordingly the Minister has agreed to take certain steps which he believes will meet the situation.

Association Professionnelle Internationale des Médecins.

89. Those sections of the Report of the Medical Secretary of the proceedings of the Annual Conference of the A.P.I.M., 1928, appearing in Appendix I, which are relevant to the functions of the Insurance Acts Committee were submitted to it and the action taken by the Medical Secretary was approved.

National Insurance Defence Trust.

90. A copy of the audited statement for the year 1927, and a statement of the income and expenditure for that year, in respect of the National Insurance Defence Trust is submitted in Appendix V.

Ophthalmic Benefit.

91. It has been ascertained that there is very little likelihood of the Ministry of Health (as a result of the provisions of the 1928 National Health Insurance Act) issuing in the immediate future any draft Regulations as regards the administration of Ophthalmic (Additional) Benefit by approved societies. It is possible that this delay may be due to the fact that the recent valuation of approved societies may result in some societies ceasing to give ophthalmic benefit, and also partly to a desire on the part of the Ministry to watch the progress of the scheme (approved by the A.R.M., 1928) of the Association in conjunction with the Association of Dispensing Opticians under which the services of ophthalmic medical practitioners are being made available to insured persons, their dependents, and others who are unable to make private arrangements with an ophthalmic medical practitioner, provided always that the family income from all sources is under £250 per annum.

In view of this situation the Council approved of the National Ophthalmic Treatment Board (at present composed of representatives of the Association and of the Association of Dispensing Opticians) putting into operation the scheme agreed by the Association. As a result facilities are being made available whereby that class of the population above referred to may obtain at a rate appropriate to their economic status the services of ophthalmic medical practitioners. The scheme has been discussed with representatives of approved societies with a view to the scheme as far as it applies to insured persons entitled to benefit being adopted by approved societies generally.

The Association is under an obligation to secure that some such facilities as the above be put into operation in accordance with the undertaking given by its witnesses before the Departmental Committee on the Sight-Testing Opticians (Registration) Bill that the Association would co-operate with any suitable body in an effort to make available the services of ophthalmic medical practitioners at a rate which would fit the economic circumstances of insured persons and others in a like economic condition. The necessity for everything being done to make a success of the above mentioned scheme cannot be too strongly impressed upon every section of the medical profession. The failure of the efforts of the Association in this connection will place a powerful weapon in the hands of the protagonists of State recognition of opticians. Such a failure would be regarded as an indication that the medical profession is either unable or unwilling to supply the service in question at a price which the members of the community concerned are able to afford or to support it when established. While this appeal is made primarily to those interested in ophthalmic work, the bearing of the scheme on other departments of medical practice must be fully recognised. The statutory recognition of opticians would undoubtedly greatly encourage other sections of unqualified practitioners, *e.g.*, osteopaths, in their efforts to obtain similar recognition.

Hospitals.

REVISION OF HOSPITAL POLICY.

92. The Annual Representative Meeting in the following Minutes gave instructions for the amendment of the Hospital Policy in certain directions:—

Minute 219 *of A.R.M.*, 1927.—Resolved: That the R.B. instructs the Council to consider the formulation of a Middle Class Hospital Policy.

Minute 183 *of A.R.M.*, 1928.—Proposed by the Chairman of the Hospitals Committee:—

That paragraph 22 of the Voluntary Hospital Policy (United Kingdom) be amended by the insertion of the following, as sub-paragraph (c), present sub-paragraphs (c) and (d) being renumbered (d) and (e) respectively:—

(c) If the treatment of the patient involves the application of special skill or experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess, then the attending practitioner before undertaking the treatment should satisfy one or more of the following conditions:—

(i) that he holds or has held hospital or other appointments, affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service to be rendered, and has had actual recent practice in performing the service to be rendered or services of a similar character, or

(ii) that he has had special academic or post-graduate study of a subject which comprises the service to be rendered, and has had actual recent practice as aforesaid, or

(iii) that he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service to be rendered.

Minute 184 *of A.R.M.*, 1928.—Whereupon an amendment by M. W. Renton (Dartford), and seconded by N. Bishop Harman (Council):—

That the words "of a degree or kind which general practitioners as a class cannot reasonably be expected to possess" be deleted.

The amendment was carried.

Minute 185 *of A.R.M.*, 1928.—Upon being put as the substantive motion, an amendment by H. G. Dain, seconded by W. A. Marris (both of Birmingham Central):—

That the motion (Min. 183) as amended (Min. 184) be referred back to the Council until the Council reports on Middle Class Hospital Policy.

The amendment was carried; also as the substantive motion.

With regard to the instruction to formulate a Middle Class Hospital Policy, the Council considers that the best method of dealing with this matter is, not by the issue of any separate policy, but by the incorporation in the existing policy of paragraphs which will bring that policy into line with present requirements and deal with the new conditions arising as a consequence of the demand which exists for hospital provision for the middle classes.

The Council recommends:—

Recommendation: That it is not desirable to formulate a separate Middle Class Hospital Policy, as suggested in Minute 219 of the A.R.M., 1927, but that the position be met by amending the Voluntary Hospital Policy (United Kingdom).

The Council also recommends:—

Recommendation: That the amendments to paras. 16-24 of the Voluntary Hospital Policy (United Kingdom) contained in Appendix VI, be adopted in order to give effect to Minute 219 of the A.R.M., 1927, and Minutes 183-5 of the A.R.M., 1928.

SEPARATE HOSPITALS OR INSTITUTIONS (NOT CONNECTED WITH VOLUNTARY HOSPITALS) FOR PAYING PATIENTS.

93. Another matter which has been considered by the Council is the provision of separate hospitals or institutions (not connected with voluntary hospitals) for paying patients, and as the Association has no policy which completely covers the position the Council has drawn up the policy and rules contained in Appendix VII, which it recommends to the Representative Body for adoption.

Recommendation: That the appended policy and rules for private patients admitted into separate hospitals or institutions (not connected with voluntary hospitals)—(*see* Appendix VII)—be adopted.

HOSPITAL POLICY AS APPLIED TO COTTAGE HOSPITALS.

94. As experience had shown that in the case of cottage hospitals some differentiation should be made between the method of remuneration of a medical staff which is restricted and that of one which is unrestricted, the Council proposes the following recommendation:—

Recommendation: That the new paragraphs contained in Appendix VIII be substituted for present paragraphs 40 and 41 of the Voluntary Hospital Policy (United Kingdom).

MODEL CONTRIBUTORY SCHEME FOR HOSPITAL BENEFIT.

95. In order to assist medical staffs of hospitals in their consideration of contributory schemes, the Council considered it advisable to prepare a model in which the fundamental principles enunciated by the Association in relation to such schemes were incorporated. The model contributory scheme for hospital benefit as adopted by the Council is shown in Appendix IX.

PROVISION OF PAY BEDS FOR LONDON.

96. The Pay Beds Committee appointed by the King Edward's Hospital Fund for London in May, 1927, issued its Report in July, 1928. The Committee consisted of the late Viscount Hambleden (Chairman), Sir John Rose Bradford (President of the Royal College of Physicians), Sir Bernard Mallet, Mr. V. Warren Low, F.R.C.S., and Prof. Winifred Cullis, D.Sc. Its reference was to enquire into the question of hospital accommodation in London, for persons prepared to pay more than voluntary hospital patients. The Committee ascertained that there are, at present, in London 1,055 pay beds, a number which, in the opinion of the Committee, falls short of the necessary requirements by about 5,000. The Committee recommended the provision of pay beds on an extensive scale at from 4 to 6 guineas a week for the benefit especially of the professional and middle classes whose position as regards medical attention in serious illness leaves much to be desired. To meet the need for such provision the suggestion is made that there shall be a steady expansion of the present accommodation by way of new wings to existing hospitals and possibly of the establishment of separate hospitals for patients who would pay fees on a graduated scale. The establishment of a mutual insurance

scheme to help persons of moderate means to meet the cost of maintenance and medical fees when in hospital is advocated. The Committee in general recommends that voluntary hospitals should make it a recognised part of their function to provide pay beds for the middle classes by means of fresh accommodation so as to prevent the use of beds by a class for which the beds were not originally intended. The proposal is made that hospitals should provide accommodation at charges which shall show a clear profit, thus providing a new source of revenue for the hospitals. In the main, the Council is in agreement with the proposals suggested in the Pay Beds Committee's Report, although on an important point contained in para. 128 and Conclusion (iv) the Report of the Committee diverges from the Hospital Policy of the Association. Para. 128 and Conclusion (iv) are as follows:—

> *Para.* 128.—"It seems to us that if patients are provided with special pay bed accommodation at less than cost price, they are essentially in the same position in relation to the voluntary system as patients in ordinary wards. Here, again, we do not recommend that the King's Fund should make a hard and fast rule which would condemn particular arrangements, such as those which may, for instance, be in force in connection with special charities for the assistance of middle class patients of limited means. But, as the general principle for any considerable development of the pay bed system, we hold that no patient in a pay bed should pay any fee to a physician or surgeon, whether a member of the medical staff or not, for treatment received in the hospital, unless the charges which that individual pays to the hospital cover the whole cost to the hospital of his current maintenance and of any special service he receives from the hospital.
>
> *Conclusion* (*iv*).—That no patient in a pay bed should pay any fee to a physician or surgeon, whether a member of the medical staff or not, for treatment received in the hospital, unless the charges which that individual patient pays to the hospital cover the whole cost to the hospital of his current maintenance and of any specific services he receives from the hospital.

The Council cannot agree with the suggestion contained in the last part of paragraph 128 and Conclusion (iv) as it is diametrically opposed to the policy of the Association.

In its consideration of the problems involved in connection with the provision of pay beds, the Council wishes to emphasise the importance to the patient and to the practitioner of continuity of treatment. At the present moment, the admission of a patient to a pay bed attached to a general hospital in London or indeed in other areas, means as a general rule that the practitioner loses touch with his patient, as in such pay beds the patients' private medical practitioners are seldom allowed to continue treatment of their own patients.

The Council considers that whenever possible, the patient should remain under the care of his or her own private practitioner throughout the whole course of the illness, the practitioner calling in any consultant who may be required. This would obviate the invidious position in which a member of the visiting staff of a hospital is often placed when he has to take over in the hospital pay bed the patient of a colleague simply because that colleague has no access to the pay beds and not because the patient prefers the services of a member of the staff.

The general tenor of the Report of the Pay Beds Committee indicates that that Committee is prepared to favour alternative schemes for the provision of pay beds, and accordingly the Council, while recognising the need for some increase of beds for paying patients in existing hospitals, and recognising the importance to the patients of continuity of treatment by their own practitioners, has urged the King Edward's Fund for London to encourage the establishment of separate institutions of sufficient size to permit of the patients therein deriving the benefits to be obtained from a large and efficiently administered hospital with ancillary services, whilst at the same time remaining under the medical charge of their own private practitioners with free choice of consultant.

The King Edward's Hospital Fund for London has replied to the Association's representations stating (a) that the King's Fund was concerned only with voluntary hospitals and accordingly the final conclusions of the "Pay Beds Committee" Report dealt only with the principles to be aimed at in any general extension of the pay bed system in connection with voluntary hospitals; (b) that the "Pay Beds Committee" stated that it regarded the question of the treatment by private practitioners of patients in pay beds attached to voluntary hospitals as one which the Board of Management of each hospital should decide for itself; (c) that the Management Committee was of opinion that the General Council of the Fund would not desire to express any opinion on the question of the medical staff arrangements at pay beds in connection with voluntary hospitals other than that taken up by its "Pay Beds Committee"; (d) that the question of the separate pay bed hospital was contained in following paragraph 6 of the Report of the Management Committee to the General Council of the Fund:—

> 6. After discussing the place which might be occupied in any comprehensive scheme by the separate pay hospital and the private nursing home, the Report bases its recommendation of an increase in pay beds and of an insurance scheme for the middle classes, in association with the voluntary hospitals, on the argument that:—
>
> "The present-day definition of the functions of the voluntary hospital system includes provision not only for the sick poor in the original sense of the term, but also, on suitable terms of payment, for all those who, while not coming within the definition of the necessitous poor, are unable to obtain without some such assistance the medical treatment they need";

and that the following paragraph 9 of that Report:—

> 9. The Management Committee . . . consider that, while the assistance of the hospitals in providing treatment for ordinary hospital patients is the primary function of the King's Fund, the Fund would be promoting the welfare of the hospitals by encouraging (so far as this is within its power under its Act of Incorporation) the provision of a reasonable number of pay beds for persons of moderate means, and the establishment of an insurance scheme whereby as many as possible of such persons may place themselves in a position to pay for their cost,

showed that the question had already been raised as to how far it came within the province of the King's Fund to encourage or assist in the provision of pay beds even in connection with voluntary hospitals, and the Management Committee was of opinion that the General Council would regard the establishment of separate self-supporting pay bed institutions as being wholly outside the scope of the Fund; and (e) that in these circumstances the Management Committee was doubtful whether an interview between representatives of the Association and the Fund (which had been asked for) would carry the matter any further, but if the Association still desired such an interview, the Management Committee would be pleased to appoint representatives.

The Council has decided to ask the King Edward's Fund to arrange for a conference between representatives of the Association and the Fund to discuss further the questions relating to the provision of pay beds in London.

Definite proposals regarding the admission to and treatment of private patients in separate homes or hospitals not connected with voluntary hospitals are put forward in Section 92 and Appendix VI of this Report. The importance of providing separate institutions catering for the class above the ordinary hospital class cannot be over-estimated, and if the suggestions which the Council has made to the King Edward's Fund for London were carried into effect they would go a long way to solve the difficulties which at present exist. The conditions under which private practitioners should be allowed to treat their patients in the private wards of hospitals and in annexes or homes connected with voluntary hospitals are outlined in Sections XI and XII (Appendix VI) of the amended Hospital Policy now presented by the Council.

Industrial Accidents and Hospitals.

97. With reference to the following resolution of the A.R.M. 1928:—

> *Minute* 188.—Resolved: That the following motion be referred to the Council for consideration:—
>
> Motion by Newcastle-on-Tyne: That industrial accidents should not be a charge on the voluntary hospitals or on the services of the visiting staff,

the Council recommends:

> **Recommendation:** That there are two ways by which industrial accidents need not be a charge on voluntary hospitals or on the services of the medical staff, namely by:—
>
> (i) making a charge on industry, which would require legislation; and
>
> (ii) the development of contributory schemes, in connection with which the services of the medical staffs are recognised in accordance with the policy of the Association.

and that the following paragraphs of the Voluntary Hospitals Policy (United Kingdom) apply to this position:—

> 9. Contributions to hospitals by employers of labour or massed or periodical contributions by employees should be considered as contributions for services rendered or to be rendered.
>
> 32. Where the Board of Management of a voluntary hospital accepts contributions for patients from an approved society, insurance company, contributory scheme, employer of labour, and/or by massed or periodical payments by employees, the members of the visiting medical staff should receive recognition of their services either in the form of an agreed honorarium, or by means of a percentage of all such payments being passed into a special fund. Such honorarium or fund can be allocated in any manner which the visiting medical staff may determine.

Assistance to Hospital Staffs in Support of Hospital Policy.

98. A conference of representatives of the medical staffs of voluntary hospitals held on 6th June, 1928 (convened by the Council), passed the following resolution:—

> That the British Medical Association be requested through its Council and central organisation to support the staffs of voluntary hospitals when approaching their Committee of Management in order to secure the adoption of the British Medical Association Hospital Policy.

The Council, after due consideration, has come to the conclusion that the time is not yet ripe for the enforcement of the Hospital Policy by making a general demand for the remuneration of the visiting staffs, and believes that progress will be best obtained if the initiative comes from the staffs themselves backed by the full support and assistance of the Council and central organisation.

Whenever an application has been, or is, received from the medical staff of a hospital for assistance in attempting to get the Hospital Policy adopted in relation to that hospital, such assistance as is possible from headquarters or through the appropriate Division or Branch of the Association is given. This assistance takes the form of advice in accordance with the Policy, visits by an officer or official of the Association and personal advice, letters from headquarters or Division or Branch to the Board of Management, and deputations from the Division or Branch to the Board of Management.

Co-ordination of Hospital Provision.

99. A copy of the scheme for co-ordination of hospital provision adopted by the Representative Body, 1928 (Minute 152), was sent to the Ministry of Health on 22nd September, 1928, with an intimation that the Council would be prepared, should the Ministry so desire, to nominate representatives to discuss the scheme. So far the Ministry has only acknowledged this communication. A copy of the scheme was also sent to the British Hospitals Association with a request that that Association would supply the Council with a copy of the report on co-ordination of hospital provision which it was understood it had sent to the Ministry, but the British Hospitals Association has so far only discussed the general principles on which such a schemehmight be based. A conference between representatives of the two Associations will probably take place soon.

(Attention is also directed to paragraphs 121 and 125 of this Report under the heading "Poor Law Reform.")

Radiologists Working at Hospitals.

100. For some time past the British Institute of Radiology has been in conference with the Association with a view to a memorandum being drawn up interpreting the Hospital Policy of the Association as applied to radiologists working at hospitals. The Institute proposes, when the memorandum contained in Appendix X has been approved by the Association, to adopt it as its policy and to arrange for it to be circulated to all hospitals and other authorities concerned. The matter has been considered by a Sub-Committee on which the Institute was represented and the Council now presents a memorandum for this purpose, and recommends:—

Recommendation: That the memorandum on the interpretation of the Hospital Policy for Radiological Services (*see* Appendix X) be approved.

Naval and Military.

Period of Office of the Director of the Royal Air Force Medical Service.

101. The Council reports the following correspondence which has ensued with the Air Ministry on the question of the period of office of the Director of the Royal Air Force Medical Service:

(a) *Letter to Air Ministry, dated 7th February, 1929.*

"The Naval and Military Committee of this Association has learned from questions asked in the House of Commons that the Director of the Royal Air Force Medical Service has been granted a period of extension which will bring his tenure of this office to a period of nine years by November, 1930. As it appears that no definite period of tenure is laid down for those who hold this office it is not possible to calculate the full effect of stagnation of promotion which follows, but if a period had been assigned which approximated to that laid down for the Director General of the Royal Naval Medical Service, of the Royal Army Medical Corps, and of the Indian Medical Service, at least one officer and possibly two might have enjoyed the prestige and emoluments of this office by that date, and it must be very discouraging to officers who have seen this valuable post within their reach to find suddenly and quite unexpectedly that they can never attain to it.

The extension of time beyond the normal period for certain senior officers in the R.A.M.C. immediately after the war caused a serious block in promotion to the higher ranks of that Service. This caused a great feeling of grievance in the lower ranks which has had disastrous effects on recruiting. A similar result is quite likely to follow in the R.A.F.M.S.

My Committee, which is keenly interested in the well-being of the medical services of the fighting Forces of the Crown, very greatly regrets that at a time when there is a marked shortage of candidates for Commissions in all these Services, anything should be done which is likely to increase further their present unpopularity.

While it is recognised that it is too late to alter what has been done, the Committee hopes that in order to prevent any repetition, steps will be taken without delay to fix a period of tenure for the office of Director of the Royal Air Force Medical Service in order that candidates for the Service may know the prospects of high office in the Service; and it would seem reasonable to adopt the period of three years which has been found to work well in the Royal Naval Medical Service, the Royal Army Medical Corps, and in the Indian Medical Service.

As a considerable number of medical officers in the R.A.F. are members of this Association and naturally look to it to deal with general questions affecting the popularity and efficiency of their Service, I should be glad to be favoured with your comments on the position in order that I may be able to answer those who are asking what step the Association is taking in the matter, which has aroused wide interest and considerable discontent."

(b) *Reply dated 23rd February, 1929.*

"I am commanded by the Air Council to acknowledge receipt of your letter of the 7th February, in which you suggest that a period of tenure should be fixed for the office of Director of Medical Services.

(2) The Council regret that they are unable to adopt this suggestion. The prospects of the officers of the Royal Air Force Medical Service and their general well-being are, of course, matters to which they have always given, and will continue to give, their fullest and most careful consideration. They are, however, satisfied that at the present stage of the development of the Royal Air Force as a whole and its Medical Service in particular one of the most important desiderata is continuity of administration.

(3) They have therefore reached the definite conclusion that, without prejudice to the conditions which may obtain in the future, the formulation of any definite term for the head of this Service would, in present circumstances, be likely to militate against its efficiency, which must naturally be the paramount consideration."

Reorganisation of the Medical Services in India.

102. The Council in its Supplementary Report in June, 1928, stated that it had considered the decision of the India Office concerning the reorganisation of the Medical Services in India and had informed the Secretary of State for India that the new proposals would not attract an adequate number of European medical men so long as:—

(a) the posts of Chief Administrative Medical Officers of Local Governments are not specifically included in the list of

appointments reserved for officers of the Indian Medical Service; and

(b) the prospect of employment on the civil side which is the chief inducement to enter the I.M.S. is as indefinite as it is at present.

The Council has received a reply from the India Office on the points referred to, the contents of which it is not at the moment at liberty to divulge, but it hopes to be in a position to make a definite statement in the Supplementary Report. The Council is, however, satisfied that the India Office is doing all it possibly can to meet the wishes of the Association.

CONDITIONS OF SERVICE IN THE ROYAL NAVAL MEDICAL SERVICE

103. The Council in 1928 raised with the Admiralty the question of the desirability of there being an upper limit in the promotion zone. The Admiralty expressed the opinion that the advantages of the present system outweighed any possible disadvantages, and in the circumstances the Council decided to defer consideration of the matter for a period of 12 months.

The Council has now given this matter close consideration and has come to the conclusion that, while the proposal would enable Surgeon-Captains to serve longer, the ultimate result would be a block in promotion, and that therefore it would be undesirable to proceed further in this matter.

Medical Benevolence.

104. During the twelve months ending December 31st, 1928, the amounts collected by the Association for those medical charities for which the Association acts as a collector were as follows, the figures for the previous year being given for the purpose of comparison:—

	1928. £ s. d.	1927. £ s. d.
Royal Medical Benevolent Fund...	1,671 16 5	1,271 14 7
Epsom College	1,207 13 2	909 17 3
Royal Medical Benevolent Fund Society of Ireland	43 0 6	31 19 0
Sir Charles Hastings Fund ...	177 5 3	143 0 0
	£3,099 15 4	£2,356 10 10

In addition the sum of £1,636 10s. 10d. was received for distribution among existing medical charities at the discretion of the Trustees of the B.M.A. Charities Trust Fund. This amount was distributed as follows, the amount distributed in 1927 being also given:—

	1928. £ s. d.	1927. £ s. d.
Royal Medical Benevolent Fund ...	800 0 0	800 0 0
Epsom College	500 0 0	500 0 0
Royal Medical Benevolent Fund Society of Ireland	—	60 0 0
Sir Charles Hastings Fund ...	109 11 3	116 13 6
Royal Medical Benevolent Fund Guild	226 19 7	270 0 0
	£1,636 10 10	£1,746 13 6

It will be seen from these figures that, although not quite so much money was received in 1928 for distribution at the discretion of the Trustees of the Charities Trust Fund as was received during 1927, there was a net increase of £633 1s. 10d. in the amount which the Association was able to hand over to medical charities. This is, of course, gratifying, but the Council believes that a much greater increase could be shown if every Division would follow the excellent example set by some Divisions and make it part of their duty to see that the needs of medical charities are brought to the notice of the local practitioners. The claims for relief are increasing, and a much greater annual income is needed if they are to be adequately dealt with.

Divisions were asked last year to furnish a report of their activities in connection with medical charities during 1927, and were told that a similar report would be called for in respect of 1928. A circular letter has therefore been sent to Divisions asking for the 1928 report, and it is proposed to put before the Representative Body in the Council's Supplementary Report a statement of what the various Divisions are doing in this matter.

Scotland.

OPENING OF THE EXTENDED SCOTTISH HOUSE.

105. The extended premises were formally opened on 4th October, 1928, the proceedings taking the form of a Conference of Secretaries of Branches and Divisions in Scotland with the Scottish Committee. There was a large attendance of Secretaries, practically every area being represented. The Chairman of the Scottish Committee, Dr. G. W. Miller, presided, and subjects discussed were:—The B.M.A. Charities' Fund; the proposals for reform of Local Government (Scotland); the Scale of Salaries for officers in the Public Health Service; Regional Professional Hospital Committees; and the membership in Scotland.

The Secretaries were afterwards entertained to luncheon by the members of the Scottish Committee. Sir Robert Philip, Past President of the Association, presided, and the extensions were formally declared open by Sir Robert Bolam, Chairman of the Building Committee.

CONFERENCE OF STAFFS OF VOLUNTARY HOSPITALS.

106. A well attended and representative meeting of staffs of voluntary hospitals in Scotland was held on 17th November, 1928. Dr. G. W. Miller presided, and an address was given on the Hospitals Policy of the Association by the Deputy Medical Secretary. An interesting discussion followed, from which it appeared that opinion upon various aspects of the policy was fairly equally divided, but no formal decisions were taken. The Conference unanimously approved the proposal to establish Regional Committees

LOCAL GOVERNMENT (SCOTLAND) BILL.

107. The Council gave careful consideration to the provisions of the Local Government (Scotland) Bill and approved generally of the proposals as being in line with the policy of the Association and particularly the combination of the various local bodies dealing with health into one local authority. On the question of whether local authorities should have power to provide and maintain hospitals for the treatment of sick persons the Council urged upon the Department of Health for Scotland the desirability of powers being given to local authorities to make, apart from the Poor-law, such hospital provision as may be needed, subject to the condition that provision shall be determined in relation to the whole hospital facilities of the area. Effect was given to these representations by amendment of the Bill in Committee.

RE-ORGANIZATION OF BRANCHES AND DIVISIONS.

108. Consideration has been given to the question of re-organization of Branches and Divisions in Scotland so as to bring them more nearly into line with the boundaries of the new local health authorities. While of opinion that this should be done so far as possible, the Council recognises the difficulties and has invited the opinion of Branches and Divisions on the subject.

NOTIFICATION OF PUERPERAL PYREXIA.

109. In reply to the request of the Department of Health for Scotland for the views of the Association on a proposal that puerperal pyrexia should be made notifiable, the opinion was expressed that puerperal pyrexia should be notifiable in Scotland under regulations analogous to those which have been adopted in England.

Wales.

110. The economic conditions in South Wales and Monmouthshire are well known to everybody and need no emphasis. These conditions have had their natural effect on medical practice in the affected areas, and the Council considers this to be an opportune time for a brief review of the situation, both in its present and future aspects. This review is the result of careful enquiries made by the Welsh Committee.

In the South Wales mining areas almost the entire income of general practitioners is derived from two sources, namely, the National Health Insurance capitation fee and the "poundage system," though in a minority of areas a capitation rate of payment is made on behalf of the dependents of insured persons. The "poundage system" by which the miners pay for medical attendance on their families consists of a deduction of so much a pound from their weekly earnings. When employment and wages are good the miner prospers and so does his doctor. When work is slack and wages bad the doctor suffers along with the miner. The closing of the pits in many areas and the greatly reduced employment in others have resulted in the local practitioners being almost entirely dependent upon the insurance capitation fee. In the meantime the families of the miners have received whatever medical attention and medicines they required, and these services have been given freely. No action has been taken to press for any kind of payment from the unemployed miners. The Council is pleased to report that quite recently in a few districts some of the miners have voluntarily made a small payment to the doctors, out of their unemployment pay, towards attendance on their families, a sign of a desire to retain self-respect under great difficulties.

Bad times have been previously experienced but the degree and duration of the present depression have never been equalled. Well-established practitioners in good times had an opportunity of consolidating their financial position against such adverse times but the younger men and the doctors in the capitation areas have been very hardly hit.

There are indications that a definite improvement in the coal mining industry is in sight, and, with a return to comparatively normal conditions, the question of payment for attendance on the dependents of miners will have to be reviewed *de novo*. But even allowing for a progressive improvement in the industrial situation in South Wales and Monmouthshire, there appears to be no prospect of the prosperity of former years returning. There are some thousands of former miners and other associated workers who will never get work in or about the mines again. In these circumstances it is felt that a note of warning should be sounded, and that practitioners in search of a livelihood should not be encouraged to settle in South Wales without realising that the future prospects are not hopeful.

Ireland.

ACTIVITIES OF IRISH BRANCHES.

111. The Irish Branches were during the past year more active than in previous years, and gave a good deal of time and attention to many medico-political matters affecting intimately the interests of the profession. The Branches, amongst other urgent matters, gave much attention to the arrangements made between the governing bodies of clinical hospitals and local authorities for the treatment of school children in connection with medical inspection and child welfare schemes, and intimated to the parties concerned that the medical staffs should be consulted with regard to proposed contracts in which medical treatment was involved. This request has been readily agreed to. The question of remuneration remains for the most part unsettled, but it is hoped that further negotiations will, in this respect, arrive at an agreement.

LOCAL AUTHORITIES (OFFICERS AND EMPLOYEES) ACT, 1926.

112. No legislation of a purely medical character, or affecting indirectly the medical profession, has taken place during the past year either in the Dáil or in the Northern Parliament. An amending Bill was, however, introduced into the Dáil by the Opposition, which provided under the Local Authorities (Officers and Employees) Act, 1926, that, instead of sending only the name of the candidate placed first on the list by the Selection Board, a panel of candidates, consisting of at least three names, should be forwarded to the local authorities so that they might have a selection from which to make a choice. This proposal was strongly opposed by the Government, which held that it would defeat the main purpose of the Act, which was to secure the appointment of the candidate placed first on the list by the Selection Board. Practically all medical appointments in the Free State are now made under the Local Authorities (Officers and Employees) Act. The Amending Bill was defeated by a large majority. The Government, however, undertook to appoint a Select Committee to consider proposals for the better administration of the Act. One of the two medical members of the Dáil appointed to act on this Committee is the Irish Medical Secretary. Evidence has been invited from local authorities, medical bodies, and officials' organisations affected by the Act. The Irish Medical Committee, on behalf of the medical profession in the Free State, has submitted a memorandum of evidence in which it stated that the present method of appointment under the Local Authorities Act is a great advance on the methods previously followed. It believes that more efficient medical officers are being appointed, and that the selections are carefully made. The Committee also pointed out that it has been brought to its notice that since the Act came into operation young medical men and women are devoting themselves in increasing numbers to improving their knowledge by post-graduate study, and by seeking the higher diplomas and degrees in order to have a better chance of gaining appointments. The Committee pointed out certain defects in the Act which should be remedied and amongst its recommendations are the following

(1) Appointments to the medical service should be made as the result of competitive examination, aided by the consideration of the qualifications, post-graduate experience, and character of the candidates.

(2) A roster of accepted candidates should be made twice a year, containing a number of names equal to supplying the estimated vacancies for the ensuing half-year. The adoption of this method would avoid, as at present, the necessity for repeated fees and interviews arising out of the frequent applications as individual vacancies occur.

(3) Promotions as well as new appointments should be brought within the control of the Local Appointments Commission.

The Committee dealt at some length with the recent development of the Appointments Commission making a competent knowledge of the Irish language a determining factor in making medical appointments. The Committee is in agreement with the view of the Commission that in purely Irish speaking districts, which are few, it is essential that medical officers should be able to converse with their patients in their native tongue—otherwise their work would be inefficiently performed. The Committee, however, joined issue with the Commissioners when they declare, in effect, that in deference to "the general policy of the Government respecting the importance of Irish in primary education" they will among candidates who are "suitable and thoroughly qualified" take as the deciding consideration a knowledge of Irish. The Committee submitted that the duty of the Commission is to recommend the candidate best fitted professionally to perform the duties of the post, and that the introduction of any other consideration is improper. It should not be the function of the Commission to satisfy itself that a candidate is "suitable and thoroughly qualified"; its duty is to recommend the most suitable and best qualified.

Parliamentary Elections Fund.

113. The Council as Trustee of the Medical Representation in Parliament Fund has considered applications made by medical candidates in the forthcoming General Election. Two of them have been interviewed, namely, Dr. Haden Guest (Conservative Candidate for the North Salford Division) and Dr. J. Vincent Shaw (Liberal Candidate for the Ilkeston Division of Derbyshire), and the Council is satisfied that these candidates are in general agreement with the policy of the Association and are likely to be helpful to the profession if elected. Some financial assistance has been given to these candidates and the Divisions in the areas concerned will be asked to give what assistance they can in the promotion of their candidature. Other applications may be received and will be carefully considered.

The Council is aware that the fact that the Fund has not hitherto been able to give support to medical Labour candidates has been adversely criticised, but, as has been previously explained, this discrimination is not due to the Fund having any Party prejudice, but to the fact that hitherto it has not been possible to find a medical Labour candidate who was prepared to support the policy of the Association, particularly as regards the retention of the voluntary system of hospitals and opposition to the introduction of a whole-time salaried State medical service. There seems to be some indication that the pledges exacted from Labour candidates in the past as regards these two subjects have been somewhat relaxed, and the Council wishes to make it clear that if a medical Labour candidate can be found in a suitable constituency who is prepared to support the policy of the Association it would have great pleasure in giving what assistance it could to such a candidate.

A suggestion has been made that additional subscribers to the Fund might be attracted if subscribers were allowed to earmark their subscriptions for candidates of a particular political complexion. This matter is under consideration, but in the meantime the Council recommends this voluntary Fund, which was inaugurated with the hearty approval of the Representative Body, to the attention of all members of the Association.

Psycho-Analysis.

114. The Annual Representative Meeting at Nottingham instructed the Council to investigate the subject of Psycho-Analysis and to report. A Special Committee was accordingly appointed for this purpose. The Committee (under the Chairmanship of Dr. R. Langdon-Down) has been actively at work during the past two years and has held many meetings. The Council anticipates that it will be able to report on this question in its Supplementary Report.

International Medical Sea Code.

115. The Council reported to the Representative Body last year (para. 92 of Annual Report and para. 172 of Supplementary Report) that it had drawn up a simple system of case-taking dealing with the signs and symptoms of disease and injuries for the use of master mariners when seeking medical advice by wireless from a surgeon on another ship or on shore. The Board of Trade translated this system into Code and through the co-operation of the Cunard and White Star Shipping Companies it was given a thorough practical test at sea by three members of the Committee which drew up the system. The tests showed the system to be incomplete in certain respects and it has now been considerably amplified.

The revised system of case-taking has been sent to the Board of Trade from which the following letter has been received:—

"With reference to your letter of the 30th November, regarding the proposed International Sea Code, I am directed by the Board of Trade to thank you for the report and questionnaire, which have been read with great interest.

It appears to the Board that in this matter there are two main purposes to be served; first, to ensure, so far as possible, accurate case-stating by masters of ships who send out requests for medical advice by wireless telephone and secondly to facilitate medical consultation between ships and stations of different nationalities.

With the first of these objects in view, the Board propose at once to consider the preparation of instructions for the guidance of masters of British ships when seeking medical advice by wireless; and, if the British Medical Association have no objection, they would like to use the formulary prepared by the Committee as a basis for such instructions, assuming that it is found suitable for that purpose.

The Board will also consider, in consultation with the International Committee now sitting, the possibility of including in the new International Code, now in course of preparation, a medical section based on the formulary prepared by your Committee. In any event, it will be necessary to include in the Code a number of words and phrases relating to accidents, diseases, medical assistance, etc., and the work of the Committee will be most valuable in this connection.

Some considerable time must necessarily elapse before a final decision can be reached on this latter question; but the Board propose to proceed at once with the preparation of instructions to masters, in order that such instructions may be included in the forthcoming new edition of the Ship Captain's Medical Guide."

The Council informed the Board of Trade that the Association had no objection to the use of the formulary as above described, and the Council is hopeful that this effort on the part of the Association may eventually prove to be of great benefit to the seafaring world.

Private Practice.

116. The Council appointed a Special Committee to consider Minutes 101, 163, 166 and 220 of the A.R.M. 1927 (which are quoted at the beginning of the Report in Appendix XI). The Council has dealt with the matter in two parts, the first dealing with the encroachments on the sphere of private practice by the activities of local authorities, and the second with the encroachments on the sphere of private practice by the activities of voluntary hospitals, etc.

The draft of the first part of the Report was issued to Divisions in November, 1928, with a request for their comments and it has been revised in the light of the comments received. The Report as a whole will be found in Appendix XI. The Report itself indicates the changes that have been made in the first part since the draft was submitted to the Divisions. The second part is submitted for the first time.

The Council recommends:—

Recommendation: That the Report and recommendations on Encroachments on the Sphere of Private Practice by the activities of Local Authorities, Voluntary Hospitals, etc. (*see* Appendix XI), be approved.

Puerperal Morbidity and Mortality.

117. In the Report on the Causation of Puerperal Morbidity and Mortality which was adopted by the Representative Body last year, the Council was instructed (Minutes 106 and 107 of A.R.M. 1928) to set up a Committee "to formulate measures designed to bring about reduction in puerperal morbidity and mortality rates, to keep in touch with research work, and to assist Divisions and Branches of the Association in arranging for education and propaganda with regard to the value of ante-natal service, the method of dealing with confinements and the post-partum care of the mother and the care of the infant," and the Council accordingly re-appointed the special Puerperal Morbidity Committee to deal with the scientific aspects of the matters involved in that instruction.

The Council considers that the best method of arranging for education and propaganda in regard to the value of ante-natal services, the method of dealing with confinements, the post partum care of the mother and the care of the infant, would be by post-graduate courses or lectures, preferably with demonstrations on the subject involved, and that such propaganda if successfully carried out would not only materially benefit those attending such courses or lectures, but would redound to the credit of the Association. The Council is accordingly urging all Divisions to arrange for post-graduate courses or lectures and if local lecturers cannot be found the Council to prepare to supply them.

118. The following resolutions of the A.R.M. have also been considered in this connection:—

Minute 100.—Resolved: That the following recommendation contained in paragraph 40 of the Report on the Causation of Puerperal Morbidity and Mortality be adopted:—

(2) That steps should be taken to determine by further experimental research:—

(a) The factors which constitute and the conditions which vary resistance to disease, particularly as regards pregnancy and the puerperium.

(b) The best specific prophylactic measure to employ for the prevention of infection by streptococcus pyogenes.

(c) The length of time required to acquire such immunity and the degree and duration of such immunity.

(d) The therapeutic value of specific as opposed to antiseptic measures in the treatment of septicæmia caused by streptococcus pyogenes.

Minute 101.—Resolved: That the following recommendation contained in paragraph 40 of the Report on the Causation of Puerperal Morbidity and Mortality be adopted:—

(3) That increased facilities should be provided for training medical students with special reference to ante-natal work.

Minute 103.—Resolved: That the following recommendation contained in paragraph 40 of the Report on the Causation of Puerperal Morbidity and Mortality be adopted:—

(5) That members of the medical profession should be encouraged to keep regular and careful records of their midwifery cases.

Minute 105.—Resolved: That the following recommendation contained in paragraph 40 of the Report on the Causation of Puerperal Morbidity and Mortality be adopted:

(7) That the Association should consider the allocation of additional grants to promote research into the problems raised in this report, including especially the questions raised in the second recommendation of this report (for which, *see* Minute 100 of A.R.M. 1928—quoted above).

With reference to Minutes 100 and 105 of the A.R.M. 1928 (quoted above) the Council is not yet in a position to submit any report.

As regards Minute 101 of the A.R.M. 1928 (quoted above) the Council understands that the General Medical Council is at present dealing with the provision of increased facilities for the training of medical students in obstetrics with special reference to ante-natal work. The situation will be kept under observation.

As regards Minute 103 of the A.R.M. 1928 (quoted above) the Council is asking all Division Secretaries to supply the names of practitioners in their areas who will be willing to keep careful records of their midwifery cases for a period of years, and is drawing up a form for the keeping of such records. It is hoped by this means not only to encourage the keeping of regular and careful records of midwifery cases, but to obtain a body of information which should be very useful for further action.

The A.R.M. 1928 adopted other resolutions in regard to the Report on Causation of Puerperal Morbidity and Mortality (*i.e.*, Minutes 99 and 102) which have been dealt with in the Evidence given on behalf of the Association before the Departmental Committee on the Training and Employment of Midwives on 30th January, 1929 (*see* para. 67 of this Report).

The following resolution of the A.R.M. 1928 will receive consideration when the scheme referred to in paragraph 67a has been drawn up:—

Minute 109.—Resolved: That it be an instruction to the Committee set up under paragraph 40 (8) of the Report on Causation of Puerperal Morbidity and Mortality that a full report on the scheme of organisation referred to in paragraph 34 be prepared and submitted to the Divisions at an early date.

Poor Law Reform.

LOCAL GOVERNMENT BILL.

118 (a). The provisions of the Local Government Bill introduced into Parliament by the Government, and the Explanatory Memorandum thereon issued by the Minister of Health, were considered by the Council with a view to ascertaining how far certain fundamental principles connected with health administration adopted by the Association were given effect in the Bill, and to taking whatever steps seemed to be necessary to try to get the Bill brought into line with those principles.

The Bill dealt with Poor Law, Registration of Births, Deaths and Marriages, Roads and Town Planning, Rating and Valuation, and other matters, though the Association was only directly concerned with certain sections of Part I (Poor Law) and Part IV (Miscellaneous Local Government Provisions), and the relevant financial provisions.

The Council expressed approval of the Bill in so far as it promotes unification of the medical services of the country.

Sections of the Bill with which the Association was concerned fell under three main categories:—

The effect of the Bill upon medical officers of health and poor law medical officers;

The machinery of health administration; and

The effect of the finances of the Bill upon the efficiency, or otherwise, of the health services.

Effect of the Bill upon Medical Officers of Health and Poor Law Medical Officers.

119. The Council after comparing the relevant clauses of the Bill with previously expressed opinions of the Association, approved (i) the provisions of the Bill in so far as they dealt with the hastening of the appointment of whole-time medical officers of health as opportunity serves; and (ii) the provisions of the Bill affecting questions of transfer, compensation, superannuation, etc., of existing medical officers subject to the Bill ensuring that transferred and retiring officers would be no worse off as regards superannuation than under their present conditions.

As a result of the Council's representations that the position of transferred officers as regards superannuation should not be worsened, the Minister undertook to amend the relevant clause so as adequately to protect the rights and interests of such officers in this connection. The amendment was considered satisfactory.

To the Council's request that it be made clear in the Bill that any Poor Law officer retiring, either voluntarily or otherwise, owing to the operation of the Act should be able to do so without loss of any superannuation rights, the Minister pointed out that the Bill contemplated that the persons in the service of the poor law authority shall be transferred to the new poor law authorities, where no doubt they would ordinarily perform duties corresponding to those performed at present. If their appointment was terminated by the new authority in consequence of the reorganisation on the passing of the Bill they had a right to compensation, and further, if within five years they found the duties they were required to perform were either not analogous to or were an unreasonable addition to those performed before the appointed day, they are given the right to relinquish office, and to be compensated in the ordinary manner.

Machinery of Health Administration.

120. The provisions of the Bill dealing with the above question though transferring (as from an appointed day and in accordance with administrative schemes to be submitted to the Minister) to county and county borough councils the functions of poor law authorities, differed from the expressed views of the Association in that some of the provisions are optional whereas the policy of the Association was that they should be compulsory. These are dealt with under the following heads:—

(a) Distribution of Functions,
(b) Delegation of Functions,
(c) Co-option on Committees,
(d) Statutory Local Medical Advisory Committees, and
(e) Hospital Management and Administration.

With respect to (a) Distribution of Functions, the expressed view of the Association was that it should be compulsory upon the council of any county or county borough to arrange that the transferred health duties of a poor law authority should be administered entirely apart from any transferred assistance (relief) duties and from any transferred education duties; and should be unified in administration with those health duties hitherto performed by a local authority under the provisions of any previous Act. The relevant clause of the Bill, however, provided only that any administrative scheme *may* declare that any assistance which can be provided either by way of relief or by virtue of any of the following Acts (and any amending Acts) shall be provided under the appropriate Act and not by way of poor relief:—

Public Health Act, 1875,
Local Government Act, 1888,
Mental Deficiency Act, 1913,
Maternity and Child Welfare Act, 1918,
Blind Persons Act, 1920.
Public Health (Tuberculosis) Act, 1921.
Education Act, 1921.

Under the optional nature of the clause it was possible for the council of any county or county borough merely to appoint one new Committee (Public Assistance Committee) to administer the whole of the transferred functions hitherto performed by a poor law authority *en bloc*, including poor relief, education, medical assistance, and hospital provision.

The Council, therefore, endeavoured to secure the amendment of this clause so as to make it compulsory upon councils to administer transferred health functions which can be dealt with under the Acts referred to, under the appropriate Act and not as poor relief, and to use the appropriate committees in dealing with them.

Upon the necessary amendment being moved during Committee Stage, the Minister, while stating that he thought there was no difference between the principle of the amendment and the desire of the Government, said he was not prepared to accept the amendment, but undertook to endeavour to have words included in the clause so as to indicate that local authorities ought to pursue the course advocated in the Association's amendment. The amendment was therefore withdrawn, but the wording of the clause was subsequently strengthened in the desired direction.

As will be seen from the latter paragraphs of this Report, action is being taken in an effort, *via* the Divisions and Branches, to carry the matter still further by influencing the local schemes which must be prepared by the county and county borough councils.

Consultation by County and County Borough Councils with Local Bodies as to Administrative Scheme.

121. A proposal was made by the Council to its parliamentary advisers that an amendment be proposed in the House of Commons to Clause 3 to make it compulsory that every county and county borough council shall in framing its administrative scheme consult "all parties concerned" and consider any representations made to them. The Council was advised, however, not to press this point as it might prejudice the more important point last referred to, and for other reasons.

During the consideration of the Bill in the House of Lords efforts were made by Lord Dawson and others to secure amendment of Clause 4 of the Bill so as to provide that a Council in preparing its administrative scheme should consult any body existing in the area representative of the voluntary hospitals of the area, and also any body existing in the area representing the qualified medical practitioners in the area. Lord Dawson's amendment, though receiving considerable support, was not accepted in full by the representative of the Government in the House. A new clause, however, was inserted in the Bill to the effect that the council of every county and county borough shall, before making provision for hospital accommodation in discharge of the functions transferred to them and before deciding the uses to which such accommodation shall be put, consult with such committee or other body as they consider to represent both the governing bodies and the medical and surgical staffs of the voluntary hospitals, providing services in or for the benefit of the county or county borough. The Government did not accept the proviso that a body representing the medical practitioners of an area must in the same way be consulted.

Delegation of Functions.

122. As Clause 4 (2) and (3) of the Bill only provided that a council of a county may delegate to the local education authority for elementary education its powers with respect to the education of any children maintained in an institution provided under the 1921 Education Act; and to the council of an urban district or non-county borough its powers as regards assistance which could be provided under the Maternity and Child Welfare Act, 1918, steps were taken by the Council to amend the Bill to provide that the council of a county or county borough *shall* delegate these transferred functions to the local education authority for elementary education and to those councils of districts in its area which have hitherto carried out the duties in question.

In view of the above-mentioned decision of the Minister (*see* para. 120) this amendment was not pressed.

Co-option on Committees.

123. The Association has expressed the view that all committees of local authorities dealing with health matters should contain some co-opted persons, not members of the council of the authority, among whom there should be medical practitioners though always so as to secure that elected members are in a majority on such committees. This principle of co-option has already to a certain extent been secured as regards education committees, maternity and child welfare committees, and mental deficiency committees. The Bill provided (Clause 11 (3)) that the public health committees also *may* include co-opted members.

Further, Clause 5 of the Bill provided that a public assistance committee shall be set up, the scheme for which *may* provide for co-option. If the transferred functions were not (as permitted by the Bill) administratively distributed as the Association suggested, this committee would have all health matters (*inter alia*) relating to the present poor law class referred to it, and may be given extensive executive powers.

Efforts were therefore taken to secure amendment of Clause 5 and Clause 11(3) of the Bill to make it compulsory that there be co-opted upon committees of the council dealing with health matters, persons, not members of the Council, among whom there should be medical practitioners. The amendment, however, was not pressed to a vote, and endeavours to secure the adoption of the principle in their individual schemes by the local councils are being made.

Local Medical Committees.

124. A further point which the Association had hitherto regarded as being of importance in connection with the unification of health administration was that each county and county borough council should set up a statutory medical advisory committee financed out of public funds. No such provision, however, was included in the Bill in any form.

If such committee were set up, it was proposed by the Association that the council of the area should be compelled to consult it before the council could adopt any proposals affecting the medical profession or the health of the people, although the medical committee would be a purely advisory body. The Council in the light of experience gained since the Association first adopted this principle, was by no means convinced that it would be wise to press for any alteration in the Bill to meet the point. Apart from the parliamentary difficulties, there was the fact that as there was no suggestion of the transference of the duties and powers of insurance committees to councils the obvious suggestion of the transformation of the present local medical committee into such a medical advisory committee was impracticable

In these circumstances the Council decided to make no attempt in connection with the Bill to secure the setting up of a local medical advisory committee but to press upon Divisions the increased importance of securing co-operation with the councils of local authorities.

Hospitals.

125. A further point, though not one adopted by the Association as a fundamental principle, concerned the administration of hospitals by the local authorities. The Council holds the view that the administration of hospitals might very well be in the hands of a Hospital Sub-Committee of the Public Health Committee, which Sub-Committee should by co-option include medical practitioners and lay persons experienced in the management of hospitals.

Another method of dealing with the question would be the inclusion in the Bill of a provision compelling each council to set up in respect of each such hospital, or group of hospitals in its area, a board of governors which must not consist wholly of members of the council, but shall include persons, medical and lay, experienced in the management of hospitals.

Unless one or other of these methods of administration or some method essentially similar be adopted there will clearly be grave danger either of inefficient hospital management due to inexperience, or of an entirely bureaucratic management due to reliance on officials (medical and other) solely.

Steps were taken (unsuccessfully, however) to endeavour to secure the insertion of a provision in the Bill whereby each council shall be compelled to set up a hospital sub-committee of its public health committee (or of its public assistance committee if distribution of function be not secured) to deal with hospitals, such sub-committee to include persons, medical and lay, experienced in the management of hospitals. The point has, however, been partly met by the amendment secured by the efforts of Lord Dawson and referred to in para. 121 ; and the machinery suggested is still permitted by the Bill though it is not imposed on authorities.

Effect of the Finances of the Bill upon the Efficiency, or otherwise, of the Health Services.

126. The Bill substituted the block system of grants to councils in the place of the grant-in-aid system at present in operation, and the Council addressed itself to the question of whether it was possible to safeguard the health services of the country under the proposed new system. Under this system it is possible for a council, if it so choose, to decide not to develop further any of the existing health services, or not to set up any new health service, but to proceed to spend its grants on, say, highways. In such a case, where the council had not, for example, hitherto made any provision for maternity and child welfare, or had decided to pay no further attention to this matter, or to the care of mental defectives or others, there was no effective means provided for the Minister to put financial pressure on the council. The only clause in the Bill (now Clause 96) for varying or reducing grants was apparently to be remote in operation and was hedged round with so many provisos that its value was highly problematical. As a result of prolonged discussion the Minister has taken power to reduce the grants if "he is satisfied either upon representations made to him by any association or other body of persons experienced or interested in matters relating to public health or without any such representations that the council have failed to achieve or maintain a reasonable standard of efficiency and progress in the discharge of their functions relating to public health services . . . regard being had to the standards maintained in other areas whose financial resources and other relevant circumstances are substantially similar, and that the health or welfare of the inhabitants of the area . . . . or some of them has been or is likely to be thereby endangered" ; and has inserted specific mention of maternity and child welfare and lunacy and mental deficiency, as services to which this power applies.

Action as to Local Administrative Scheme.

127. In view of the little success which attached to its endeavours to secure definite amendment of the Bill in accordance with its desire, the Council is endeavouring to secure inclusion of its points in the Administrative Schemes which must be prepared locally and submitted to the Minister of Health for approval.

To this end the Council issued, to the bodies stated, the letter set out in Appendix XII, and earnestly asks for prompt and determined action by the Divisions and Branches.

H. B. BRACKENBURY,
Chairman of Council.

APPENDIX I.

REPORT OF THE MEDICAL SECRETARY OF THE PROCEEDINGS OF THE ANNUAL CONFERENCE, 27TH TO 30TH SEPTEMBER, 1928, PARIS, OF THE ASSOCIATION PROFESSIONNELLE INTERNATIONALE DES MEDECINS.

(*Presented to the Council at its February, 1929, Meeting.*)

I have been unable earlier to present this report because I was waiting for the official report, which did not come into my hands until after the last meeting of Council. Before giving details of the Conference I think it well to submit some general information on the A.P.I.M. which is taken from a report presented to the Confederation of the French Medical Syndicates by Dr. Decourt, who was their representative on the A.P.I.M. as well as Secretary of the A.P.I.M.

General Information.

The membership of the A.P.I.M. includes 25 nations, each of which is represented by one member who, in the great majority of cases, is either the President or the Secretary of the National Group. The nations are :—Argentine, Austria, Belgium, Bulgaria, Chile, Cuba, Denmark, Dantzig, Esthonia, France, Great Britain, Germany, Holland, Hungary, Lithuania, Luxembourg, Norway, Peru, Poland, Rumania, Sweden, Switzerland, Czecho-Slovakia, Uruguay, and Yugo-Slavia.

According to the Statutes the Council of the body is composed of nine members, and one vacancy has been left for future contingencies. The present eight members are the representatives of France, Holland, Poland, Austria, Switzerland, Great Britain, Germany and Sweden. There is no permanent President, each Conference electing its own President, who this year was Dr. Paul Vuilleumier, of Switzerland.

The objects of the A.P.I.M. are to constitute a central bureau of information and of liaison between the National Groups of the medical profession, so that each may profit by the experience of the others and that they may study together various professional problems concerning the life and work of the medical practitioner. Questions purely scientific are not dealt with.

The A.P.I.M. was definitely founded in July, 1926, but it only commenced its work in January, 1927, and since that time it has sent out questionnaires asking for information on the following subjects :—

(1) The constitution and operations of the National Professional Groups;

(2) The possible means of providing collaboration between the A.P.I.M. and the International Labour Office of the League of Nations;

(3) Sickness Insurance from the medical point of view;

(4) The opinion of the Professional Groups on the Questionnaire of the International Labour Office on Sickness Insurance;

(5) Sickness Insurance (Supplementary to Questionnaire (3));

(6) Specialisation in medicine, and specialists;

(7) The liberty of prescription;

(8) Medical examination of motor drivers;

(9) The illegal exercise of medicine in different countries;

(10) Legal defence of the individual doctor from the professional point of view.

The last two went out just before the Annual Conference.

The Annual Conference, 1928.

The countries represented were Austria, Bulgaria, Denmark, Dantzig, France, Germany, Great Britain, Holland, Lithuania, Luxembourg, Norway, Poland, Sweden, Switzerland and Yugo-Slavia.

Correspondence continues with various countries which have not yet decided whether they will join or not, including particularly Italy, Spain, Canada and the United States.

Modificaton of Statutes.

In accordance with the instruction of Council I drew attention to the necessity for modifying Statute 4, which, after setting forth the composition of the A.P.I.M. and of its Executive, went on to say :—

> "The decisions of the Annual Conference (Conseil General) will be taken usually by show of hands or by secret ballot, if that is demanded by one of those present. In the same way if it is demanded by five countries, represented or not at the Conference, the decision of the Conference before becoming obligatory on the members ('executoire') must be submitted to a referendum of all the Groups."

I pointed out that this, in our opinion, seemed to affect the autonomy of the Groups and after some discussion it was unanimously decided that the following should be added to Article 4 :—

> "These decisions are only taken for the purposes of information and liaison, nothing being done to affect the liberty or the full and complete autonomy of each National Group."

Another alteration was made in the Statutes to allow the Conference to elect a Secretary of the A.P.I.M. either from among the National Correspondents or from outside. This was done in order to enable the country from which the Secretary is chosen to have a "Correspondent" (official delegate) untrammelled with office.

Revue Internationale de Médecine Professionnelle et Sociale.

It was decided to publish quarterly a "Revue" which should contain, in addition to a résumé of the answers to the questionnaires sent out by the A.P.I.M., news from the different countries as to important medico-political and social developments and a full report of the Annual Conference. It is hoped, by means of advertisements, eventually to make the "Revue" pay for itself, at any rate in part. Each "Correspondent" has a right to a limited number of copies which he can circulate to prominent members of his organisation, and in addition the "Revue" will be on sale at 1 fr. Swiss per number. The German "Correspondent" has ordered 700 copies, in addition to the normal 20 or so which will be distributed to each of the units in his Group. I have distributed most of the 20 copies sent to me, but any member of Council who is specially interested can have one on application to me.

Liaison with other International Bodies.

The Secretary reported that he had been present at the 11th Session of the International Congress of Labour at Geneva, but that nothing had transpired of special importance to the medical profession, except the fact that in 1929 the question of the medical insurance of seamen will come up for discussion, and that the International Labour Office will communicate to the A.P.I.M. the questionnaire on this subject which will be addressed to each Government. The Secretary also reported correspondence and interviews with the Institut International de Co-operation Intellectuelle, which is an organ of the League of Nations but is housed in Paris in a section of the Palais Royal given by the French Government. It is the business of this branch of the League of Nations to study the international relations of intellectual workers throughout the world, in co-operation with a National Committee in each country. It has already issued some important reports on such matters as an International Catalogue of Museums, and an Annual List of special important works dealing with the various branches of study in the different countries. Up to the present time this body has not dealt with anything specially medical, but it has shown its anxiety to be of service, if possible, in various ways, including an invitation to the official representatives of the A.P.I.M. to a Reception at the Institute, where we were received by several important officials, headed by Mr. A. E. Zimmern, a well-known English writer who is officially attached to the Institute.

Specialisation in Medicine.

This matter was the subject of a questionnaire issued last year and in order to obtain an effective discussion thereon Dr. Vuilleumier, the Swiss representative, submitted a report which gave rise to a long and very interesting discussion which brought out in a striking way the differences which exist with regard to the regulation of specialisation in medicine in the different countries. The following resolutions were adopted :—

(1) Specialisation in medicine appears to be inevitable in view of the progress of science and of medical practice.

(2) The medical specialist ought to possess a general medical culture at least equivalent to that of the general practitioner.

(3) The specialist is one who, as the name indicates and in contrast with that of the general practitioner, has specialised in the study and exercise of such special branch of medicine as he exercises exclusively or for preference, and in which he has acquired special dexterity and authority.

(4) A specialty, in the sense of a special branch of the medical art, is constituted by a domain of that art restricted to the study and the practice (intensive if not exclusive) of certain diseases or certain categories of diseases, of the pathology of certain organs and of certain functions, and of the application of certain methods of treatment and of research.

(5) It is desirable that the number of specialties should not be multiplied to infinity, but that in each country the number should be kept down to the smallest number possible.

(The reporter adduced a list of 31 specialties which, according to the answers to the questionnaire, are recognised as such in one or other of the countries belonging to the A.P.I.M.)

(6) The practice of specialties ought to be governed by a specification and regulations.

This looked like being accepted by all those present, but I said that, so far as I could gauge the feeling of my Association on this matter, it would be against any official regulation of the practice of specialties, and therefore I could not vote for this resolution. I pointed out that according to our Statutes it could only be a matter of opinion and that there could be no question of trying to get each country to establish some official regulation of specialists. They agreed and altered the word "ought" (doit) to "should" (devrait). It was agreed that on this and any other subjects discussed the opinion of the Conference was only to be used for the information, and such action of the constituent bodies as they thought proper to take.

(7) Any such regulations should be imposed by recognised medical organisations.

(8) The minimum conditions allowing a doctor to call himself a specialist should be (i) a good general medical culture at least equal to that of the general practitioner; (ii) special studies and hospital practice as assistant or "interne" or "chef de clinique" of a sufficient duration, in a service recognised as being of sufficient importance in the specialty chosen; (iii) an adequate installation.

(9) The possibility of a general practitioner becoming a specialist and of obtaining the authorisation to act as such should not be excluded.

(10) The practice of specialists should not only be controlled, but it should be inspected and power should be taken to proceed against delinquents.

(11) As a general rule a specialist should not be allowed to exercise more than one speciality.

(12) Any registered practitioner is at liberty to do any service coming within the specialty, by reason of his registration, but he should not be allowed to call himself a specialist and announce himself as such unless he has the proper authorisation.

After a long discussion, during which some of those present thought that a distinction should be made between insured persons and others, and that insured

persons should be prevented from going to the specialists direct while no attempt should be made (it being useless) to prevent the private patient from going direct to the specialist, the following was passed :—

(13) It is desirable that patients should not go directly to the specialist, but that they should be sent to him by the general practitioner.

There was considerable discussion upon the question of the fees of specialists, there being some who saw no reason why the fees of specialists should necessarily be higher than those of the general practitioner for the same service. A resolution was finally passed as follows :—

(14) It seems legitimate that all real specialists should be able to charge for the same service a higher fee than that which would be charged by the general practitioner.

(15) Any convention arrived at between the medical profession and the "Caisses" (the bodies central or local which direct the National Insurance system), where it concerns specialists only and even if the specialists concerned have a special professional organisation, ought to be arrived at between the organisation representing the profession in general, which should always consult any organisation which the specialists have set up.

MEDICAL QUESTIONS BEFORE THE LEAGUE OF NATIONS AND ITS VARIOUS BRANCHES.

The Conference unanimously passed a resolution stating that when any question of a medico-political or medico-social character (excluding questions purely scientific) were before the League of Nations or any of its Branches, representatives of the A.P.I.M. ought to be summoned and heard.

SICKNESS INSURANCE.

This was the *piece de resistance* of the Conference, and the most interesting discussion took us nearly two days. It was based upon the replies made to the two questionnaires which had been issued and upon reports drawn up by Dr. Farkas, of Yugo-Slavia, and Dr. Schneider, of Germany. The discussion brought out strongly the fact that the profession in every country has to face very much the same difficulties which were focused in our famous Cardinal Points. It was also clear to me that on the whole the profession in this country has been much more successful than that of any other country in arriving at a satisfactory *modus vivendi* between itself, the Government, and the Approved Societies. In view of a future discussion of this matter by a Commission of the League of Nations, at which representatives of the A.P.I.M. will undoubtedly be asked to be present, it was thought desirable to lay down a series of propositions, which is as follows :—

(1) The A.P.I.M. approves for the working classes of the community *(les classes materiellement faibles)* the principle of sickness insurance, which represents a great step in social progress and is a powerful factor in the prosperity and well-being of the nations.

(2) It is necessary that in the preparation of laws and regulations concerning sickness insurance and in any modification of them the voice of the medical profession, as represented by its National Group, should be heard. Doctors being the natural pillars of sickness insurance have a right to be heard on this subject and the A.P.I.M. insists upon this point with all its energy, noting that the majority of the national laws existing on this subject are faulty by reason of failing to secure the co-operation of the medical profession.

(3) The A.P.I.M. insists on the material and moral independence of the doctors in the operations of sickness insurance, not only in the interests of the profession but in the interests of the insured. The medical profession should remain always outside any conflict arising in the bodies directing the insurance system from the religious or political point of view, and the situation of the profession should be quite independent of any changes which take place in the constitution of these bodies. Experience shows that in the countries where the doctor has been given an honourable situation in the administration of the system and where he keeps his independence in the exercise of his profession, sickness insurance has developed satisfactorily.

NOTE.—It will be seen from the reference to "political and religious matters" in this connection that the British profession is much more fortunate than that of some other countries, where the situation is deplorable. Some extraordinary instances were given, showing that both political and religious influences are used to the detriment of the medical service, particularly in Austria.

(4) The A.P.I.M. is of opinion that sickness insurance, whether compulsory or voluntary, should only apply to those persons who are incapable from their own means of paying for medical attendance when needed. The system ought to be limited by an income limit which should be fixed in each country in accordance with the conditions prevailing therein.

(5) The idea underlying sickness insurance will not be thoroughly realised unless the members of the family of the insured persons are also insured.

NOTE.—A long discussion took place on this resolution. There were some who, though they approved of the resolution, did not think it was the business of a medical body to express any opinion as to the general idea underlying sickness insurance, but the great majority believed that it was necessary, in view of general experience, to state that the development of the system should be towards the inclusion of the families of persons at present insured, as, from the nature of the case, they needed medical attendance just as much as the insured persons and were in no better position to pay for it. It was thought also that it was desirable to make this declaration of policy, as in many countries the profession had been accused of thinking about nothing but its pocket and of having no views upon the social aspect of medicine. The discussion made it clear however that the inclusion of dependants raised many important and exceedingly awkward problems.

(6) In order not to eliminate the moral responsibility of the insured person, and to maintain the interest of the sick as well as of the medical profession, sickness insurance ought always to envisage the participation of the insured person in the cost of drugs and appliances, however modest such a participation might be. The application of this principle ought to be so adapted to the conditions of each country as not to prevent any person being deprived of necessary drugs and appliances. For the same reason sick pay should be calculated in such a way as to exclude any temptation to abuse the system, but it is understood that the application of these principles must be modified according to the conditions prevailing in each country.

NOTE.—I was the only person not voting for this resolution, because I said that I had no mandate on the matter and that in our country, after first suggesting that the insured person should pay something towards the cost of his medicine, so as to act as deterrent against abuse, we had abandoned the idea. Moreover, I said that our experience showed that the fears of those who had believed that without such provision there would be gross abuse of the medical service were unfounded.

It was pointed out to me by several of the other Correspondents from countries where the dependants are insured that however true my inference might be in a country where only the workers were insured, it did not apply in those countries where the families were insured. On this the opinion was very strong.

(7) One of the principal factors in the care of the patient is the mutual confidence which should exist between the patient and his doctor. From that follows the necessity for free choice, and the A.P.I.M. demands as a condition *sine qua non* for the satisfactory operation of any medical service in a system of sickness insurance that free choice of doctor should be laid down in the law governing the system.

(8) In all relations between the body governing State Sickness Insurance (Caisses maladie) and the medical profession it is necessary that collective contracts should be drawn up between the various governing bodies and the corresponding medical Groups. Each doctor accepting the conditions of the contracts must have the right to treat any of the insured persons in the area, no "Caisse" having the right to designate any special doctors for the purpose.

This principle of free choice should be considered as respected even in areas where the choice must be limited by the local conditions to the doctor or doctors who are nearest.

(9) Professional secrecy ought to be jealously guarded. In the interest of good administration it is necessary that the doctor treating the patient should furnish to the "Caisse" some justification for the absence from work of his patients, but it is a matter for the medical profession in each country to regulate this point with the Government or other appropriate bodies according to national custom.

NOTE.—There was a good deal of discussion on this, which brought out the great differences of custom in the different countries. France, which is now fighting the Government over its law of Sickness Insurance, attaches the greatest importance to this point, and believes that it will be possible to work a system of health insurance without giving to the authorities an indication of the nature of the sickness. The German representative agreed with me that the medical certificate was an important factor and that it was necessary that the "Caisse" should have the diagnosis in each case. I pointed out how we had got over this difficulty by giving a certificate to the sick person which is marked "confidential" and throws on the sick person the responsibility of either giving the certificate to the authority with the name of the disease thereon, or not doing so. The resolution passed was a much modified form of the original motion, which laid great stress on not revealing the name of the disease to any third party.

(10) Insured persons should be provided in case of need with specialist assistance and with hospital benefit.

(11) In the interests of the sick, doctors cannot accept restriction on their right to prescribe anything they think is necessary, the medical organisations engaging on behalf of the profession that there shall be no superfluous prescribing ("médication de luxe").

(12) Method of payment.—It is contrary to the proper exercise of the medical profession that the payment of medical fees should be by any system which has no relation to the amount of work done. The method of payment other than by fixed salary (which was unanimously rejected), whether the payment is made by the "Caisse" or by the insured person himself, must be left to the choice of each nation, following the desires of each national professional Group and the customs of the Country.

NOTE.—There was a long discussion on this question which brought out not only great diversity of custom but evidence of much abuse. I pointed out our experience with regard to payment per service, but I was told that the conditions in this country were evidently so different from those in nearly every other that it was felt that, speaking generally, a demand should be made for some method of payment per service according to local traditions and conditions. Whether the payment should be made by the "Caisse" or by the insured person himself is a matter to be left to the choice of each nation in accordance with the desires of the national professional Group.

(13) The administrative control of insured persons should be exercised by the "Caisse"; the professional control should be exercised by the medical profession in accordance with the system agreed by the national Group. If any technical control is needed by the "Caisse" it should only be exercised by a medical officer under the form of consultation between colleagues, giving the doctor treating the case the possibility of explaining himself in full liberty and on a perfect equality.

(14) As regards disputes of a medical character the A.P.I.M. is of opinion that there should be created special medical bodies charged with the control of the work of the profession so far as it concerns certificates of incapacity, abuses of prescribing, etc. These special bodies ought to be selected in agreement with the professional Group and should have, *vis-à-vis* the "Caisse" (the Insurance Committee in our country), the necessary independence to take its decisions in accordance with technical considerations. In the consideration of purely technical considerations the participation of lay people is not acceptable. The better the administration of the "Caisse" is organised from the medical point of view, the more it will be able to offer to the insured persons useful services. In the interest then of the insured persons the A.P.I.M. is of opinion that everything which concerns the medical service ought to be studied and regulated between the "Caisse" and delegates from the national medical Group. It follows that this Group ought to have representatives in every part of the machinery of administration which had a medical aspect.

(15) The A.P.I.M. declares that it is the duty of the "Caisse" to serve as the intermediary between the insured person and the doctors, pharmacists, hospitals, sanatoria, etc., but that the "Caisses" ought not themselves to exploit either hospitals, dispensaries, sanatoria, etc., nor factories of pharmaceutical products.

NOTE.—The last paragraph was put in to deal with the situation which has arisen in one country at least, where some of the "Caisses" had acquired factories for making pharmaceutical products and the results had been financially disastrous, also highly objectionable from the point of view of the doctors, who found themselves restricted in their choice of medicaments.

(16) For complaints and disputes either between the "Caisse" and the doctor, or between the insured person and the doctor, special jurisdictions should be created, with representatives in equal numbers of the interested persons, and with an appeal either to a superior special jurisdiction or to an ordinary Court of Law.

A.P.I.M. AND INTERNATIONAL ASSOCIATION OF SICKNESS INSURANCE BODIES.

In view of the possibility of the newly formed International Association of Sickness Insurance Bodies (Groupement international des fédérations nationales des sociétés mutuelles et des caisses d'assurances-maladie) Drs. Decourt (France), Vuilleumier (Switzerland) and Schneider (Germany) were designated to represent the A.P.I.M. in the event of any pourparlers being invited. This was objected to by the representative of Holland, who thought such action might go beyond the legitimate scope of the A.P.I.M. But the other representatives thought that the door should not be closed against possible discussions between the two bodies. Dr. Schneider said that their experience in Germany had shown the absolute necessity of getting into contact with the representatives of the "Caisses" on certain questions. The representatives were instructed that their duty, if called upon, would be simply to act as a liasion and not to enter into any agreement.

MEDICAL EXAMINATION FOR DRIVERS OF MOTOR VEHICLES.

A very interesting discussion took pace on the results of a questionnaire on this subject, which had been issued in the previous session, the reporter being Dr. Droogleever Fortuyn, of Holland. The discussion showed that there are regulations of varying severity concerning the medical examination of motor drivers in the following countries:—Bulgaria, Denmark, Dantzig, Esthonia, Germany, Holland, Hungary, Lithuania, Luxembourg, Norway, Poland, Sweden, Switzerland and Yugo-Slavia. France and Great Britain are the only two countries which have no regulation of any kind except for the drivers of certain public vehicles. In Germany, Dantzig, Poland and certain parts of Yugo-Slavia, the examination is made by an official doctor; in the other countries the authorities are satisfied with a certificate from the ordinary doctor. In Denmark and Lithuania an examination must be made every five years, and also in Norway as regards the question of sight. In Poland the authorisation to drive is limited to three years, after which time the authorities may exact a new medical examination. The discussion showed in what an embarrassing situation the private doctor is placed in those countries where a private certificate is accepted, and there was a general agreement in favour of a medical examination for all drivers of motor vehicles, with a fresh examination every year. It was suggested by the reporter that all examinations ought to be made by an official medical officer, and it was proposed that the decision of the Conference on this point should be subjected to a referendum. I objected to such a referendum on the grounds that the A.P.I.M. had done all that was necessary in placing the information it had gained before its constituent members and that it was for the different countries to deal with the matter as seemed to them best. This view was finally accepted.

SIXTH INTERNATIONAL CONGRESS OF PUBLIC AND PRIVATE ASSISTANCE, PARIS, 5TH TO 8TH JULY, 1928.

Dr. Decourt presented a very interesting report upon the findings of this Congress and pointed out what a strong tendency there seemed to be in the minds of many people to settle the future of medicine, with a strong bias towards officialising it without consulting the medical profession. Nothing was done except to note the tendencies of a body which seems mainly to talk at large and has no great weight.

THE WORK OF THE SESSION, 1928-29.

It was agreed that the following questionnaires should be issued:—

Enquiry into the illegal exercise of the profession of medicine;

Enquiry into the individual defence of the doctor;

Enquiry into the legal situation of masseurs, nurses, and other medical auxiliaries;

Enquiry into the administrative measures taken in various countries in connection with the problem of maternal mortality.

The last questionnaire was decided upon at my request and I have since drafted it in consultation with the Chairman of the Medico-Political Committee, the Chairman of the Maternity and Child Welfare Sub-Committee, Sir Robert Bolam, and the President of the Association.

Several other requests were made for the issue of questionnaires, but the general feeling was that those above mentioned would be sufficient for one year, and the proposers of the other subjects were invited to prepare questionnaires and submit them to the Secretary.

NEXT ANNUAL CONFERENCE.

According to the Statutes of the A.P.I.M. the Conference must be held every other year at the seat of the secretariat and in the alternate years at a place to be settled by the Conference preferably after invitation from one of the national Groups. On the invitation of Germany it was resolved that the next Annual Conference should be held in Berlin on the last Thursday, Friday, Saturday and Sunday in September, 1929, and that the President should be Dr. Farkas, of Yugo-Slavia.

SOCIAL FUNCTIONS.

I have already mentioned the visit to "L'Institut International de Co-opération Intellectuelle" on the first day of the Conference. After the meeting on the second day we visited the centre where the drivers of all public vehicles in Paris are examined from the psychical point of view, where M. Lahy, the Director, kept us all extremely interested with a demonstration of the apparatus used for bringing out the reactions of candidates to the various emergencies likely to arise. The process was very elaborate, cleverly designed, and very French in its logical method. On the Saturday evening we had a dinner at the Foyer Medical Franco-International. Besides the members of the Council and their wives, there were a certain number of official representatives of various French medical bodies present, who gave us a very cordial welcome. I had the honour of responding along with the representative of Germany, to the toast of the A.P.I.M.

TREASURER'S REPORT.

The Treasurer's report showed that the receipts during the past year had been £444 and the expenses £353. The subscriptions from Argentine, Belgium, Chile, Cuba, Peru and Rumania had not yet been received. The salary of the General Secretary was raised in 1928 to 1,000 francs Swiss (£41 13s. 4d.), a salary which in view of the work done by Dr. Decourt is, to my mind, derisory. The total secretarial expenses for 1927 were £290.

A discussion took place on the amount of the subscription, the Treasurer proposing that the present reduced subscription to those countries which had a depreciated exchange should be abandoned. This was strongly opposed by the representatives of Austria, Luxembourg, Czecho-Slovakia and Yugo-Slavia, who thought that the financial needs of the A.P.I.M. ought to be met rather by abolishing the upper limit of subscription, which acts in favour of the richer Associations. After considerable discussion it was resolved to eliminate from the Statutes the official recognition of the rights of countries with a depreciated currency to pay a reduced subscription, but instructions were given to the Treasurer for the present to allow a reduction, which should be no more than 25 per cent. of the total, to any country which could show good cause for such a concession.

APPENDIX II.

RETURN OF ATTENDANCES

At Council Meetings, from the termination of Annual Representative Meeting, 1928, up to and including April 3rd, 1929.

COUNCIL.

Chairman: H. B. BRACKENBURY.

NAME.	ATTENDANCES.	
	Actual.	Possible.
Chairman of Council: Brackenbury, H. B., Hendon	5	5
President: Maclean, Sir Ewen, Cardiff	5	5
Chairman of Representative Body: Hawthorne, C. O., London	5	5
Treasurer: Harman, N. Bishop, London	5	5
President-Elect: Burgess, A. H., Manchester	5	5
Past President: Philip, Sir Robert, Edinburgh	3	5
Deputy Chairman of Representative Body: Lyndon, A., Hindhead	5	5
Armstrong, J., Ballymena	4	5
Beadles, H. S., Romford	5	5
Blenkinsop, Sir Alfred, Frensham	5	5
Bolam, Sir Robert, Newcastle-on-Tyne	5	5
Bone, J. W., Luton	5	5
Bristowe, H. C., Wrington	5	5
Buchan, G. F., London	1	5
Dain, H. G., Birmingham	4	5
Douglas, C. E., St. Andrews, Fife	5	5
Dunhill, T. P., London	2	5
Eccles, W. McAdam, London	5	5
Finlay, D. E., Gloucester	3	5
Flemming, C. E. S., Bradford-on-Avon	5	5
Fothergill, E. R., Hove	5	5
Fraser, T., Aberdeen	4	5
Gomez, F. J., South Petherton	3	5
Goodbody, F. W., London	5	5
Hall, J. F., London	3	5
Henry, R. Wallace, Leicester	4	5
Hillman, G. B., Wakefield	2	5
Hudson, J., Newcastle-on-Tyne	5	5
Johnson, I. W., Bury	2	5
Langdon-Down, R., Teddington	4	5
Le Fleming, E. K., Wimborne	5	5
Leslie, R. W., Belfast	4	5
Lewys-Lloyd, E., Towyn	5	5
Loudon, J. Livingston, Hamilton	2	5
Luce, Sir Richard, London	5	5
Lumb, N. P. L., Southsea	—	5
McCutcheon, J. G., Glasgow	4	5
Macdonald, P., York	5	5
Mackenzie, S. Morton, Dorking	5	5
Matthews, J. C., Liverpool	4	5
Miller, G. W., Dundee	3	5
Murrell, Christine, London	5	5
Nuthall, A. W., Birmingham	3	5
O'Kinealy, F., London	4	5
Paterson, W., London	5	5
Patrick, J., Glasgow	3	5
Peacocke, R. C., Blackrock	3	5
Prytherch, J. R., Llangefni	5	5
Radcliffe, F., Oldham	4	5
Roche, N. J., Southsea	—	5
Snell, E. H., Coventry	5	5
Souttar, H. S., London	5	5
Starling, E. A., Tunbridge Wells	5	5
Stevens, John, Edinburgh	5	5
Street, A., London	5	5
Thomas, W. E., Ystrad Rhondda	5	5
Trotter, G. Clark, London	5	5
Turner, E. B., London	5	5
Verrall, Sir Jenner, Leatherhead	3	5
Walker, J. F., Southend-on-Sea	5	5
Watkins-Pitchford, W., Bridgnorth	5	5
Watson, Sir Malcolm, London	2	5
Wheeler, Sir W. de Courcy, Dublin	2	5

APPENDIX III.

(*For* 1928 *Financial Statement, see B.M.J. Supplement, April 27th, 1929.*)

APPENDIX IV.

DEPARTMENTAL COMMITTEE ON TRAINING AND EMPLOYMENT OF MIDWIVES.

THE WORKING OF THE MIDWIVES ACTS, 1902 TO 1926.

Memorandum (as approved by Council, 12.12.28) of Evidence submitted by the British Medical Association to the Ministry of Health.

1. The British Medical Association, with over 34,500 members, and local units operating in every part of Great Britain and Ireland, in presenting this Memorandum to the Committee on Training and Employment of Midwives claims to speak with authority for the whole body of the medical profession and particularly for the general practitioners of the country who form a very considerable part of the membership of the Association.

2. Matters pertaining to the reference to the Committee are continually under consideration by the Association in one form or another, and in 1925 the Council of the Association set up a special Committee "to consider and report on the Causation of Puerperal Morbidity and Mortality and on the administrative action, if any, that should be taken in connection with the matter." This Committee has produced two reports, both of which have been the subject of discussion by the Divisions (the local units) and twice by the Representative Body of the Association which meets annually to consider matters of interest to the profession. A copy of each of these Reports is attached hereto. It will thus be seen that the whole subject of Puerperal Mortality and Morbidity, including the subjects dealt with in the reference to the Committee of the Minister of Health, has engaged the serious, continued and detailed attention of the Association, which desires to re-state its earnest desire to help in any enquiry into any aspect of this question and in any measures which are believed by responsible bodies to be likely to assist in improving the practice of midwifery.

THE MIDWIVES ACTS.

Composition of the Central Midwives Board.

3. In 1909 the Association gave evidence before the Departmental Committee on the Working of the Midwives Act, 1902, in the course of which the following statement was made:—

> "The Association would submit that provision should be made for securing that at least one member of the Central Midwives Board should be a general practitioner, inasmuch as general practitioners alone have personal experience of the working of the Act in some important respects. If the justice of the foregoing submission be admitted, it is further submitted that the British Medical Association, both in respect of its representative character and its local organisation, is a suitable body to act on behalf of the profession in nominating such representatives."

The Departmental Committee in its report, published in 1909 (para. 83), recommended that the Society of Medical Officers of Health and the British Medical Association should each be given the right to nominate a member. This advice was not followed, so far as the Association is concerned, though the personnel of the Central Midwives Board was increased, as from April, 1921, from 9 to 14.

4. The Association would submit that by being allowed to nominate a representative it could be of service by selecting a practitioner who would carry weight with the profession and who in addition would have behind him the resources of knowledge and experience which the Association, by reason of its central and local organisation, is able to command. This knowledge and experience would, it is believed, be particularly useful in dealing with the Rules made for the conduct of the practice of midwives. The Association would therefore urge the Committee to consider whether it should not place amongst its recommendations one to the effect that the Central Midwives Board, in accordance with Section 1 (c) of the Act of 1918, should recommend that power should be given to this Association to nominate one or more persons.

Rules of the Central Midwives Board.

5. The following paragraph in Rule E. 12 is not clear:—

> "If, after ceasing to attend a case, the midwife subsequently attends a mother or child suffering from illness connected with the confinement, all rules under Section E (in so far as they are appropriate to the case) shall apply."

This would seem to imply that the midwife, if recalled at any time after she has left a case, may call in a doctor if she thinks fit, using Form M. 2 to summon him. The Association would submit that it should not be the duty of a midwife to decide, after a limited period, whether or not the condition is due to the confinement. In such cases she should decline to attend and advise that a doctor be sent for.

The Association suggests that a maximum time be fixed after which the midwife should be regarded as having finished with the case, and that this time be 28 days or at the end of her extended attendance for a condition which she has notified within the 28 days as requiring an extended period of attendance.

6. *Rule E. 13.* This rule has been found in practice to be misleading and the Association therefore suggests that it should be deleted as either unnecessary or contradictory to Rule E. 21.

7. *Rule E. 19.* This rule states that the midwife must note in her Register of Cases "each occasion on which she is under the necessity of administering or applying in any way any drug other than a simple aperient . . . ."

The Association has on many occasions protested to the Ministry of Health and to the Central Midwives Board against the assumption that a midwife should be allowed to administer drugs other than a simple aperient or ergot after delivery. The midwife under present regulations receives instruction in the use of drugs, but the Association contends that she is thereby being led to assume dangerous responsibilities for which there is no real need. In the short time at her disposal the training of the midwife on this subject must obviously be directed merely to the immediate effect of a few drugs on certain conditions. In the nature of the case there can be no training on the remote and general action of drugs on the patient—a very different thing requiring that scientific training which it is the object of the medical curriculum to give. Drugs which need to be administered during the course of a confinement are such as opium, chloral and pituitrin—all powerful and potentially dangerous. The Association holds that conditions in which drugs of this nature seem to be needed are indications that a doctor had better be summoned.

The objection of the Association to the use by midwives of drugs, other than a simple aperient or ergot after delivery, is supported by the action of the great majority of the local supervising authorities, who have discouraged the use of drugs by midwives in their areas.

8. *Rule E. 20* contains the following paragraph:—

> "In calling in medical assistance under this Rule the midwife shall send for the registered medical practitioner desired by the patient, or, if the patient cannot be consulted, by the responsible representative of her family."

The Association has reason to believe that the spirit of this rule is often evaded by midwives, who take advantage of their position, and, instead of giving the choice freely to the patient, induce her or her friends to send for a doctor favoured by the midwife. A case recently reported is very instructive. In a certain town, from July, 1927 to September, 1928, there were 100 emergency midwives calls and 13 doctors were employed. One doctor received 56 calls, the remaining 44 cases being divided amongst 12 practitioners. Of 30 calls made by one midwife all were sent to one particular doctor, and in the case of another midwife with 11 calls, this same doctor was employed on 9 occasions.

If there is to be real collaboration between midwives and doctors in the midwifery practice of this country there must be no suspicion even of arrangements of this kind. It is known, in the example given above, that many of the patients were in the ordinary way the patients of other doctors who were not unwilling to attend if called upon. If by undue influence on the part of the midwife or collusion between midwife and doctor the emergency work in an area is directed into one or two channels, not only will resentment be caused, but there will be lack of interest in midwifery practice on the part of the general body of the local practitioners and any hope of a general improvement in midwifery practice by co-operation between doctor and midwife will be ruined so far as that area is concerned.

The Association recommends that the paragraph from the Rule, already quoted, should, suitably emphasised, be placed at the beginning of the Rule.

9. *Rule E. 21.* It is considered that it would be better if this paragraph were removed from the Rules and put in an Appendix to Rule E. 20, the *Note* being put first for emphasis. At present, in spite of the appended Note the list of abnormalities given in the Rule is liable to give the idea that the list is an exhaustive one. In the opinion of the Association the intention of the Board would better be attained if more stress were laid in Rule 20 on "*any* abnormality" and the list of common abnormalities relegated to an appendix.

10. It is suggested that para. (4) of Rule 21 should be amended to read "Rise of temperature 99.4° F. for 24 hours," as in practice it is often found that unless the temperature has remained at 100.4 for a period of 24 hours, midwives do not consider it necessary to advise the summoning of a doctor.

11. Also it is recommended that still-births should be added to the list of emergencies in which the midwife is required to summon a doctor.

12. *Rule E. 25.* The Association submits that it should not be necessary to subject to inspection a midwife who in a particular case is acting as a maternity nurse in conjunction with a doctor and has given notice to that effect to the local authority. Preamble B. to Section E. of the Rules states that a woman who is on the Midwives Roll and who is acting as a maternity nurse is only subject to certain Rules, of which Rule E. 25 is not one. But it is not clear whether the exemption from Rule E. 25 applies, or can be made to apply, to a particular case in which a midwife practising in the area has given notice to the authority that in regard to that case she is acting in conjunction with a doctor as a maternity nurse. It is considered that nothing should be done to undermine or lessen the responsibility of any medical practitioner in charge of a case, and that accordingly when an inspector of midwives visits a patient's house, enquiry should first be made if a doctor is in charge, and, if so, no further action should be taken.

Form M. 2.

13. This is the form used by a midwife when she requires medical aid. It came into use as a result of the Midwives Act of 1918 which empowers the local authorities to guarantee a fee to the doctor called in on the advice of a midwife in emergency. Prior to its adoption there had often been difficulty in getting a doctor in these cases owing to the almost universal difficulty of obtaining a fee for services rendered, often under most onerous conditions. Since the form came into use this difficulty has practically disappeared. There are, however, occasional complaints which show the importance of ensuring that the receipt of the form by a doctor shall constitute for him an absolute guarantee of a stated fee.

Instances have occurred in which the local authority has refused a fee on the ground that the form should not have been used in the particular circumstances. These cases have always been cleared up by appeal to the Ministry of Health but there should be no excuse for quibbling of this kind.

Local authorities have also refused to pay where a doctor has been summoned (by the use of the form) more than four weeks after the confinement, on the ground that in the scale issued by the Ministry of Health to local authorities in December, 1922, there occurs the following paragraph:—

> "No fee shall be payable by the local authority (1) . . . . . , (2) . . . . . , (3) in respect of any services performed by the doctor on any date later than the tenth day from the date of his first attendance, unless he has reported to the local supervising authority that he considers, for reasons stated by him, that his further attendance is necessary, or in respect of any services performed by the doctor *after the expiry of four weeks from the day of birth.*"

The Association recommends that the liability of the local supervising authority in all cases in which the services of the doctor are requested on form M. 2 shall be placed beyond doubt.

GENERAL.

Post-Mortem Examinations in Maternity Deaths.

14. It is understood that some witnesses before the Committee have advocated the holding of a post-mortem examination on every woman dying in childbirth. The Association is strongly against any such proposal, which, if adopted would add a new terror to the practice of midwifery. Not only would it affect injuriously the doctor and the midwife, whose anxieties in such cases are already acute enough, but it would cause great perturbation amongst the public, whose prejudice against post-mortem examinations is well known. Moreover, the detailed enquiry into all maternal deaths which has recently been instituted by the Ministry of Health should obviate the necessity for even suggesting post-mortem examination in all but a very small minority of cases. The efficiency of this enquiry is however entirely dependant on the extent to which the records supplied by the doctor are treated as strictly confidential in all circumstances. Any doubt as to this would be fatal to the success of the enquiry.

Transfer of Maternal Cases to Hospitals.

15. The Association understands that suggestions have been made that there might be some addition to the Rules of the Central Midwives Board authorising midwives to send patients to hospital direct. The Association would deprecate this suggestion, because, if followed, it might encourage midwives to send many cases to hospital instead of summoning a doctor and leaving the responsibility for decision to him. Any wide use of such an authority would undoubtedly prevent that growth of co-operation between midwife and doctor which the Association is anxious to foster.

It is believed that in London a midwife can obtain an ambulance direct for the purpose of sending an urgent case to hospital and, with the reservation above made, the Association agrees that an acute emergency may override the rule that a doctor must be sent for in all cases of abnormality.

Obstetric Consultant or Specialist.

16. The Association understands that it has been suggested that a midwife might herself call in an obstetric consultant, but the Association is anxious to emphasise the principle that the calling in of the services of an obstetric consultant should remain as at present in the hands of the doctor.

The "Handy Woman."

17. The Association believes that it would be an ideal arrangement if there could be a certified midwife in attendance at every confinement, even when a medical practitioner is also in attendance, but at present this is not practicable as, apart from the financial obstacle, there are not sufficient midwives in every area. In existing circumstances it will often be necessary to use the services of a woman not holding the Central Midwives Board certificate, but the Association would deprecate the application of the term "handy woman" to *every* nurse who does not hold a C.M.B. certificate and may be assisting at a confinement. There is ample evidence that there are many such women who, though not fully trained as midwives have received training as maternity nurses and are quite competent to act under the direction of the doctor.

THE STATUS OF THE MIDWIFE.

18. There is no doubt that the Midwives Acts and their administration by the Central Midwives Board have done much to improve the education and therefore the status of the midwife, and the British Medical Association cordially approves of anything which improves the efficiency and status of such useful servants of the public. In the report of the Association's special Committee on the Causation of Puerperal Morbidity and Mortality great stress is laid on the necessity of cordial co-operation between the midwife and the doctor. The Association is pledged to do all that it can to bring about this co-operation. It is therefore necessary to get clear ideas of the position of the two parties in the midwifery service of the country. The midwife must be regarded as an auxiliary to the doctor, for though she is allowed to practise midwifery independently, and, indeed, is protected from competition by unqualified persons (a protection not extended to, or asked for by, the medical profession), her practice must be carried out in accordance with rules which enjoin the calling in of the doctor whenever *any* abnormality is noticed. The midwife then is a practitioner in *normal* midwifery who is dependent on the help of the doctor in *all* cases of abnormality.

19. The Association deems it necessary to stress this point, because there is a tendency in some quarters to think and to teach that the improvement of the education and status of the midwife is the main if not the only way of securing a higher standard of midwifery practice and consequently a lower rate of maternal mortality and morbidity. Such a view is, in the opinion of the Association, entirely wrong. There are many people in this country, among the working class as well as among other classes, who prefer to be attended in their confinements by medical practitioners, and anything that is done to minimise either directly or indirectly the necessity for a thorough education in midwifery of the medical student would, it is believed, be fatal to progress. In view of the fact that, however much the education of the midwife may be improved, it will always be necessary to have the doctor ready to deal with abnormalities, the Association emphasises the necessity for an adequately trained body of doctors, as well as of midwives. If there is any value in a liberal education it is clear that the doctor, with his preliminary scientific education, followed up by a long and arduous training in scientific methods, should always be the bedrock on which the medical services of the country, including midwifery, must be built up. Midwifery, an essential part of the training of all medical students, is, like the whole of the practice of medicine, an art founded on science. Hence the stress placed by all medical educational authorities on the necessity for a thorough training of the medical student in the basic principles of science. The Association is satisfied that the General Medical Council, the body responsible for the curriculum of the medical student in this country, is fully alive to the necessity for maintaining or improving the standard of training in midwifery in the various Medical Schools and has taken active steps to that end during the last few years. The Association therefore trusts that the Committee will keep well to the fore the essential character of the medical service in the provision of assistance for the mothers of the country. If this be done, and with the comparatively few and slight alterations in the Rules of the Central Midwives Board which have been suggested in this

Memorandum, the position should be clear and there should be no obstacles in the way of cordial co-operation between midwife and doctor, it being always recognised that women have freedom of choice as to whether they will be attended by a doctor with or without a midwife, or by a midwife alone if the case should be normal.

The Ideal Midwifery Service.

20. There is no truth in the impression that doctors as a profession are unwilling to engage in the practice of midwifery. Whatever may have been the case, at some times, or in some areas, it was never true of the profession as a whole, and it is certainly not true at the present time when there are better opportunities for a doctor to exercise his skill.

The Association believes that the ideal thing would be the provision *ab initio* for every pregnant woman of a midwife and a doctor, the latter taking complete responsibility, ante-natal, natal and post-natal, for the case, attending at the confinement if thought necessary by himself or if desired by the patient, or if sent for by the midwife on her finding some abnormality. It is believed that such joint provision, if it could be achieved, would vastly improve the practice of midwifery and would thereby render it safer. Such a provision would ensure medical supervision and responsibility throughout the pregnancy and after the confinement, ensuring skilled advice for normal cases and attendance for abnormal; and would provide for the mother that trained nursing attendance after the confinement which is so important and which so many women do not now get.

21. It should not be difficult, and it is certainly to be aimed at, even under present conditions, that the doctor who may have to attend the confinement shall have previous knowledge of that contingency. The expectant mother should therefore be encouraged to make contingent arrangements with her chosen doctor, instead of leaving this until the emergency has arisen.

22. The difficulties are, of course, mainly financial, but as regards a large section of women of the working class, namely, insured women and the wives of insured men, the difficulty should not be insuperable and the possibilities of such a scheme have already been explored by the Royal Commission on National Health Insurance which reported in 1926.

23. The following is an extract from that part of the Association's evidence before the Royal Commission which dealt with the provision of ante-natal attendance for insured women and the wives of insured men:—

> The relationship of maternity work to the health insurance scheme requires special mention. At present, attendance in connection with confinement is expressly excluded from medical benefit, and such public provision as insured women and the wives of insured men can avail themselves of is under other auspices and is not complete in character. The Association is of opinion that attendance in connection with confinement should be brought into close and proper relationship with medical benefit in general, and that, in addition to a cash payment, provision should be made under the insurance scheme whereby insured women and the wives of insured men should be entitled both to suitable ante-natal supervision and to attendance at confinement and during the puerperal period. It would no doubt be preferable, if possible, that this attendance should be given throughout by a registered medical practitioner. A large proportion of normal births are however at present attended by midwives only, and as this appears generally to be satisfactory an insurance scheme can scarcely be expected to provide more than this in such normal cases. Nevertheless, it is clearly desirable that any abnormality that could be discovered before the actual confinement should have been noted, that any practitioner consenting to be called in by the midwife in any abnormal condition should have had previous knowledge of the case, and that there should be proper means for dealing with any abnormality that may arise. Within these limits, therefore, every maternity case should be in relationship with a responsible medical practitioner, though if the mother arranged for the actual attendance of such practitioner in respect of a normal confinement this would be an arrangement outside the insurance provision. Provision for a woman within the insurance scheme as set forth in this Memorandum would thus be for (a) ante-natal medical examination (if requested by her) and supervised, (b) attendance by a registered midwife during normal labour and the puerperal period, (c) attendance by the practitioner of her choice during labour and the puerperal period when his attendance is requested by the midwife under defined conditions or when as the result of his ante-natal examination he has declared his personal attendance to be necessary. Professional services under these headings would be remunerated as in the case of the other extra services, by a special scale of fees.
>
> Certain conditions are absolutely essential if any arrangement of this kind is to be effective. Such conditions are: (1) any insurance practitioner should be at complete liberty to undertake or to decline this work without any administrative detriment to his interests otherwise; (2) any complaint as to treatment in connection with this work must be referred to a solely professional committee on which the local administrative authority should be represented by its medical officer; (3) there must be everywhere an efficient service of registered midwives; (4) the consultant and specialist service should be available; (5) there should be provision for institutional treatment for serious cases of ante-natal complications, for cases requiring major obstetrical operations, for cases where isolation and treatment of septic infection is specially indicated, and for cases where the home conditions are very unsuitable or dangerous for confinements; (6) any registered practitioner should be at liberty to place his or her name upon the list for maternity purposes only. The procedure would thus be for the insured woman, at an early stage of pregnancy, to consult the insurance practitioner who, in the great majority of cases, would accept the responsibility for maternity attendance. If the insurance practitioner did not accept this responsibility it would be his duty to arrange for consultation with (and, if desired, ante-natal examination by) another practitioner chosen by the woman, who was prepared to accept this responsibility in accordance with the scheme. If during pregnancy, at confinement, or during the puerperium conditions arose which in the opinion of the practitioner necessitated consultation with a specialist or institutional treatment, such consultation or treatment would be available under the ordinary conditions of the service as set out in other paragraphs of this Memorandum.

24. The Ministry of Health representative, in answer to questions on this subject, gave the following reply:—

> "This is a matter that has been discussed several times with the medical profession in 1919 and since, and I think that the general feeling is that if the requisite financial arrangements could be made, it would be very desirable to end the present system under which you have the general practitioner responsible for treatment before labour but having no responsibility during labour, the midwife, under an entirely independent authority, giving attendance in labour and calling in a practitioner to attend in labour, if necessary, who would be paid by the local authority; then you have the maternity and ante-natal centre giving assistance in the early stages. There is a great deal of overlapping and probably a good deal of waste, and it would be most desirable, if it could be arranged, to have a scheme that brought the family doctor, the midwife, the specialist if necessary, and all the services that are available at the maternity centre, under a common scheme and a common control, so that they each played their proper part and were brought into proper relation with each other, helping one another instead of acting at a distance as they do now." (Q. 23,896.)

25. The Royal Commission in their (Majority) Report said:—

> "It is not so much the money payment that is of importance as the question of taking steps to secure that every woman receives proper attention from doctor or midwife in suitable surroundings during a reasonable period centred on the confinement. In other words the character of the benefit should change from 'cash' to 'health' and it should be linked up with the other related health services."

26. The Royal Commission were much exercised as to the order in which they should put the extensions of medical service which they proposed to recommend. The first one recommended was the provision of a specialist and consultant service, and owing to their being "impressed by the evidence submitted to us as to the failure of the present benefit to effect any reduction in the rate of maternal mortality," they came to the decision to give a very early place to an extended provision for maternity. As a matter of fact none of these extensions have been made.

The Minority Report of the Royal Commission recommended that maternity benefit should be expanded to cover medical and midwifery services, in addition to a cash payment.

The Association is still of opinion that the biggest advance in the provision of an improved maternity service would be gained by action under the National Health Insurance Acts.

27. A compromise may be suggested, failing the adoption of the improved maternity benefit which the Association has advocated. In order to encourage insured women to submit to ante-natal examination it might be made possible that when a woman produces a certificate showing that

Continued in next column.

APPENDIX V.

NATIONAL INSURANCE DEFENCE TRUST.

(A) Balance Sheet, 31st December, 1928.

LIABILITIES.	£ s. d.	£ s. d.
To Capital Account: Balance 31st Dec., 1927 ..	127,472 11 8	
Less Payment made in computation of Income Tax Liability to April 5th, 1928 ..	9,000 0 0	
	118,472 11 8	
Add Excess of Income over Expenditure as per account annexed	28,278 15 8	
		146,751 7 4
		£146,751 7 4

ASSETS.	£ s. d.	£ s. d.
By Investments represented at average cost by:—		
£2,500 Central London Railway 4½% Redeemable Stk.	2,325 0 0	
£5,000 Commonwealth of Australia 5% Stock 1935-45	4,906 5 0	
£5,000 Commonwealth of Australia 5% Stock 1945-75	5,000 0 0	
£15,000 Consols 2½%	8,362 10 0	
£15,500 Conversion 3½% Stock	11,603 2 6	
£10,000 Conversion 4½% Stock	9,730 0 0	
£10,000 Consolidated Loan 4%	8,560 0 0	
£15,000 Funding Loan 4% 1960-90	13,045 12 6	
£5,000 India 3½% Stock	3,518 15 0	
£10,000 India 5½% Stock 1932 ..	10,125 0 0	
£5,000 New South Wales 4½% Stock 1935-45 ..	4,690 12 6	
£5,000 New South Wales 5% Stock 1935-55 .. .	4,771 17 6	
£5,000 New Zealand 4½% Stock 1944	4,868 15 0	
£5,000 New Zealand 5% Stock 1935-45 ..	5,106 5 0	
£15,000 London County Consolidated 4½% Stock 1945-85	14,520 0 0	
£5,000 Queensland 5% Stock 1940-60 ..	4,662 10 0	
£1,500 Treasury Bonds 5½% 1930	1,530 0 0	
£5,960 15s. 6d. Treasury Bonds 5% 1933-35 ..	5,981 8 1	
£12,000 Union of South Africa 5% Inscribed Stock 1933-43 ..	12,030 0 0	
£5,000 Victorian Government 3% Consol. Inscr. Stock 1929-49 ..	3,615 12 6	
		138,853 5 7
Market Value at 31st Dec., 1928, £140,910 18 6		
By Loans— British Medical Association	6,500 0 0	
Essex Public Medical Service £350 0 0		
Less: Repayment during the year £50 0 0		
	300 0 0	
		6,800 0 0
By Cash at Bank...		1,098 1 9
		£146,751 7 4

We have examined the above Balance Sheet with the books of the Trust, and find it to be in accordance therewith.

We have verified the Investments and Bank Balances.

(Signed) PRICE, WATERHOUSE & CO.

3, Frederick's Place, Old Jewry,
London, E.C. 2.
7th March, 1929.

a medical practitioner has examined her at the end of 32 weeks of her pregnancy, she shall be entitled to receive a proportion (*e.g.*, one-half) of the maternity benefit due under the National Health Insurance Acts. This would without compulsion secure the supervision of the case by a doctor and would have the additional advantage that the person concerned would receive some monetary benefit at a time when such benefit could be best applied to the purpose for which it is intended, namely, the provision of additional nourishment for the mother and her baby. At the present time the maternity benefit is often not received by the mother until three or four weeks after the baby has been born, when, generally speaking, the most important time during which extra nourishment is required has passed. The remainder of the maternity benefit should be payable to the mother on the completion of the confinement.

28. While the Association is of opinion that ante-natal work can be done quite efficiently in the patient's house or at the doctor's consulting room the maternity and child welfare centres may have a very useful function in this connection, especially if such clinics are staffed, wherever possible, by the practitioners of the neighbourhood. The Association does not wish to minimise the usefulness of the centres at present existing, and recognises that there are some things, *e.g.*, education of the mother in the care of the infant and in mothercraft, which can probably be better done collectively at a centre where the services of trained and expert nurses can be provided than in any other way. But so far as the ante-natal provision is concerned, there is nothing done at the centres which could not be done equally well by a doctor who undertook full responsibility for the case, either at his own surgery or in the house of the mother, and it seems to the Association that there is every argument in favour of that same doctor being made responsible for the health of the mother and the child throughout the whole ante-natal and post-natal period, rather than splitting up the responsibility in any way, particularly as that doctor would usually also be the person to be consulted in other conditions affecting the health of the mother and family.

APPENDIX V (*continued*).

(B) Income and Expenditure Account for the year ending 31st December, 1928.

	£ s. d.		£ s. d.
To Repayment to B.M.A. of Expenses in connection with—		By Subscriptions	23,577 12 2
(a) Annual Conference of Local Medical and Panel Committees, 1928, and election of direct representatives on Insurance Acts Committee, 1928-29;		,, Dividends and Interest on Investments ..	4,875 18 1
(b) Proportion of railway fares of Insurance Acts Committee when meeting on same day as Trustees and certain Sub-Committees and Deputations, and		,, Interest on Loans ..	296 0 0
(c) Printing in connection with collection of statistics as to amount of work done by insurance practitioners	563 9 8	,, Profit on Sale of 5% War Loan	1,369 3 0
,, Honoraria, etc., to practitioners in connection with the presentation of the case of insurance practitioners of a county area at enquiry held by the Minister of Health into the administration of medical benefit in the area	56 3 6		
,, Honoraria to Members of Central Advisory Committee	99 15 0		
,, Income Tax on untaxed Interest and Dividends	173 6 10		
,, Miscellaneous Printings	275 15 6		
,, Postages	155 0 0		
,, Petty Cash	48 15 6		
,, Railway Fares	65 0 6		
,, Legal Charges	292 18 7		
,, Honorarium of Clerk ..	32 16 6		
,, Charges incurred in purchase of stock	76 16 0		
,, Excess of Income over Expenditure for the year subject to balance of Income Tax for nine months to 31st December	28,278 15 8		
	£30,118 13 3		£30,118 13 3

APPENDIX VI.

SUGGESTED AMENDMENTS OF PARAS. 16-24 OF VOLUNTARY HOSPITAL POLICY (UNITED KINGDOM).

PRESENT POLICY.

V. *Suitability of Patients for Hospital Treatment.*

16. The primary consideration in the admission of a patient to hospital should be the suitability of the case on medical grounds.

17. Some means of investigation into the circumstances of the applicants for relief, by means of an almoner or other agent, should be employed in all medical charities.

VI. *Categories of Patients for In-Patient Treatment.*

18. Patients admitted to voluntary hospitals should be classed under the following groups: "Free" (Indigent), "Tariff," and "Private":—

(a) *Free (Indigent) Patients.* Those certified by the almoner or other officer of the hospital as unable to contribute in any way towards their maintenance and treatment;

(b) *Tariff Patients.* Those paying, or for whom is paid, in part or in whole, the tariff cost of maintenance and treatment: this group includes all those for whom any payment has been made by (i) Public Authorities; (ii) Approved Societies, Employers of Labour, Insurance Companies, or other bodies; or (iii) under any contributory scheme; and

(c) *Private Patients.* Those who pay for special accommodation and who arrange for medical treatment fees independently of the hospital.

VII. *Free (Indigent) In-Patients.*

19. Those certified by the almoner or other officer of the hospital as unable to contribute in any way towards their maintenance and medical treatment; and for whom hospital benefit is provided by the gratuitous contributions placed at the discretion of the hospital managers and by the gratuitous services of the honorary medical staffs.

20. Cases of obvious destitution or cases already in receipt of poor-law relief should, after they have been seen once in the casualty or out-patient department, be referred to the poor-law relieving officer, unless they should be retained by the hospital for treatment. But in case of patients referred by poor-law medical officers to hospital for consultation or treatment, payment should be required from the poor-law guardians both for advice, treatment and maintenance.

VIII. *Tariff In-Patients.*

21. When the Board of Management of a voluntary hospital enters into a financial arrangement with an Employer of Labour, a Public Authority, Approved Society, Insurance Company or any other body, or under a contributory scheme for the reception of patients, such arrangements should be taken to cover the full cost of maintenance and medical treatment, and should provide as follows:—

(a) Payments made for tariff in-patients should be for work done, based upon a tariff of fees agreed upon from time to time between the contracting parties; such tariff of fees making full allowance for provision of hospital accommodation, maintenance and payment of medical staff.

(b) The accounts of the hospitals should be kept so as to show the cost of this hospital benefit.

(c) Inability to pay for adequate treatment as a private patient, whether in the hospital or outside, should be the consideration for the admission of all tariff patients for hospital treatment.

(d) All persons, whether insured under the National Health Insurance Acts or not, whose income from all

SUGGESTED AMENDMENTS.

V. *Conditions Governing Admission to Hospital.*

16. The primary consideration in the admission of a patient to hospital should be the suitability of the case on medical grounds. (*Existing para.* 16.)

VI. *Categories of Patients.*

17. Patients admitted to voluntary hospitals should be classified by the almoner or other officer of the hospital in the following groups:—

(a) Free.

(b) Contributing,

the latter being divided into:—

(i) Aided.

(ii) Tariff.

(iii) Private.

VII. *Free Patients.*

18. Those certified by the almoner or other officer of the hospital as unable to contribute in any way towards their maintenance and medical treatment; and for whom hospital benefit is provided by the gratuitous contributions placed at the discretion of the hospital managers and by the gratuitous services of the honorary medical staffs. (*Existing para.* 19.)

19. Patients referred by Medical Officers of Public Authorities to voluntary hospitals for consultation or treatment should be paid for by the Public Authorities, and classed as Tariff patients.

VIII. *Aided Patients.*

20. Those certified by the almoner or other officer of the hospital as unable to contribute towards their maintenance and treatment an amount which brings them within the category of tariff patients.

21. Hospital benefit for patients coming within this category is provided by two sources of income:—

(i) the contribution made by or on behalf of the patient and from this the visiting medical staff should receive an agreed share;

(ii) the gratuitous contributions placed at the discretion of the hospital management in respect of which the visiting medical staff ask for no financial recognition.

No aided patient should be admitted without the recommendation of an attending practitioner, except in the case of emergency.

IX. *Tariff Patients.*

22. Those paying or for whom is paid a fixed tariff sum which covers the whole maintenance charges borne by the hospital together with an agreed addition for the remuneration of the visiting medical staff.

The amount of the tariff in any hospital will be fixed from time to time by agreement between the parties concerned having regard to the average cost of maintenance in the hospital at the time.

23. This group should include, with others, those for whom payment is made (a) by Public Authorities, (b) by Approved Societies, (c) by Employers of Labour, (d) by Insurance Companies, (e) by other bodies, or (f) under any contributory scheme.

24. All persons whose income from all sources does not exceed the limits of a specified scale should be eligible for hospital benefit on tariff rates. The hospital should reserve its right to challenge admission.

PRESENT POLICY.

sources does not exceed the limits of a specified scale should be eligible for hospital benefit on tariff rates. The hospital should reserve its right to challenge admissions.

(The following maximum scale is suggested, subject to economic and local variations and to periodic revision:—

Class 1.—*Limit of Income* £200.

(a) Single persons over 16 years of age.

(b) Widow or widower without children under 16 years of age.

Class 2.—*Limit of Income* £250.

(a) Married couples without children under 16 years of age.

(b) Persons with one dependent under 16 years of age.

Class 3.—*Limit of Income* £300.

(a) Married couples with a child or children under 16 years of age.

(b) Persons with more than one dependant under 16 years of age.)

(e) For those persons whose income places them beyond the agreed specified scale for tariff patients, arrangements may be made to receive them as private patients, for the conditions governing which, *see* paragraphs 22 and 23 below.

(f) The ordinary hospital routine of admission, transference and discharge of patients should not be modified for tariff patients nor should any preferential treatment be given to them.

(g) No tariff patient should be admitted without the recommendation of the attending practitioner, except in the case of emergency.

IX. (A) *Private Patients in Nursing Homes attached to Hospitals.*

22. Where it is desirable that special accommodation in the nature of a nursing home should be provided in connection with voluntary hospitals for the reception of private patients, there should be provided as follows:—

(a) Private patients should be admitted to such special accommodation only on the recommendation of a private practitioner, except in cases of emergency. In the latter circumstances the patient's own medical attendant should be informed.

(b) It should be open to a private patient to select any registered medical practitioner as his attendant.

(c) The scale of charges for the private patient for maintenance should be such as fully to cover every cost to the hospital.

(d) No fixed rate of payment for professional services rendered to such patients should be established; the fees so payable to remain, as at present, a matter of arrangement between patient, family physician and consultant.

(B) *Private In-Patients in Hospitals.*

23. Where private patients are admitted under special arrangements into the public wards of a voluntary hospital:—

(a) Private patients should be admitted to such wards only on the recommendation of a private practitioner, except in cases of emergency.

(b) The scale of charges for the private patient for maintenance should be such as fully to cover every cost to the hospital.

(c) No fixed rate of payment for professional services rendered to such patients should be established; the fees so payable to remain, as at present, a matter of arrangement between the patient and the member of the staff of the hospital.

(d) The accounts of the hospitals should be kept so as to show the costs of this hospital benefit.

(e) The ordinary hospital routine of admission, transference and discharge of patients should not be modified for these private patients, nor should any preferential treatment be given to them.

SUGGESTED AMENDMENTS.

(The following maximum scale is suggested, subject to economic and local variations and to periodic revision:—

Class 1.—*Limit of Income* £200.

(a) Single persons over 16 years of age.

(b) Widow or widower without children under 16 years of age.

Class 2.—*Limit of Income* £250.

(a) Married couples without children under 16 years of age.

(b) Persons with one dependant under 16 years of age.

Class 3.—*Limit of Income* £300.

(a) Married couples with a child or children under 16 years of age.

(b) Persons with more than one dependant under 16 years of age.) (*Same scale as in existing policy.*)

No tariff patient should be admitted without the recommendation of an attending practitioner, except in the case of emergency.

25. The ordinary hospital routine of admission, transference and discharge of patients should not be modified for tariff patients nor should any preferential treatment be given to them. (*Existing para.* 21 (*f*).)

X. *Private Patients.*

26. Where special accommodation is available in connection with voluntary hospitals persons whose income is above that laid down in the scale for tariff patients may be admitted as private patients.

27. Private patients should not be admitted to the public wards of a hospital except as a matter of urgency pending their removal to a private ward as soon as convenient; while in the public ward the appropriate conditions set out in paras. 28 and 29 should apply.

28. If in an emergency a private patient is admitted without the cognisance of his private medical attendant, the latter should be informed immediately.

XI.—*Private Patients in Private Wards of Hospitals.*

29. When the special accommodation takes the form of private wards in a hospital which has both public and private wards in the same building, then—

(a) if the hospital has a resident medical officer or officers and also a staff of consultants who are ordinarily responsible for the care of all patients in the public wards—the patient should be under the responsible care of a member of the visiting staff, in association with the private practitioner of the patient who should have free access to the patient and should have such share of responsibility and treatment of the patient as may be agreed upon unless in the case of any such hospital, arrangements have been made by the Governing Body to permit the access of practitioners not on the staff to have responsible care of their own patients, when the provisions of para. 30 should apply.

(b) if the hospital has not a resident medical officer or officers and/or a staff of consultants who are ordinarily responsible for the care of all patients in the public wards the patient should be admitted under the responsible care of a private practitioner and should be allowed, if necessary, to call in any consultant of his choice;

(c) the appropriate medical fees payable by the private patient in conditions mentioned above may be determined either according to a scale agreed between the medical staff and the board of management, or by private agreement between the medical attendant and the patient.

XII.—*Private Patients in Annexes or Homes connected with Voluntary Hospitals.*

30. When the special accommodation takes the form of a separate home or hospital provided exclusively for such patients, such home or hospital being an annexe of or connected with a voluntary hospital having public wards:—

PRESENT POLICY.

SUGGESTED AMENDMENTS.

X.—*Out-Patients.*

(a) the patient should be allowed to select any available registered medical practitioner as his attendant;

(b) if the treatment of the patient at any time involves the application of special skill or experience then the practitioner undertaking that treatment may be required to satisfy one or more of the following conditions:—

(i) that he holds or has held hospital or other appointments, affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service to be rendered, and has had actual recent practice in performing the service to be rendered or services of a similar character, or

(ii) that he has had special academic or post-graduate study of a subject which comprises the service to be rendered, and has had actual recent practice as aforesaid, or

(iii) that he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service to be rendered;

(c) the fees for medical attendance should be either a matter of arrangement between patient and medical attendants, or according to a scale of fees agreed between the Medical Staff and the Board of Management.

That the heading of existing Section X of the Hospital Policy "Out-Patients" be amended to read "Out-Patients: Additional Provisions."

(*For Policy re private patients admitted into separate hospitals or institutions not connected with voluntary hospitals, see Appendix VII hereto.*)

APPENDIX VII.

PRIVATE PATIENTS ADMITTED INTO SEPARATE HOSPITALS OR INSTITUTIONS NOT CONNECTED WITH VOLUNTARY HOSPITALS.

Where a private patient is admitted into a separate hospital or institution provided exclusively for such patients, such hospital or institution being an independent institution not connected with a voluntary hospital,

(a) the patient should be admitted only on the recommendation of a private practitioner except in case of emergency, in which case the patient's own medical attendant should be immediately informed;

(b) the patient should be allowed to select any available registered medical practitioner as his attendant;

(c) the fees for medical attendance should be entirely a matter of arrangement between patient and medical attendants, no fixed rate of payment being established in this case;

(d) subject to the above provisions practitioners giving treatment at the institution should be subject to any rules formulated for the conduct of the institution by its Governing Body.

RULES FOR SEPARATE HOSPITALS OR INSTITUTIONS FOR PAYING PATIENTS NOT CONNECTED WITH VOLUNTARY HOSPITALS.

(i) There should be a Governing Body of each private hospital on which the medical profession should be adequately represented; such representation should be not less than one-third of the total number of the Governing Body.

(ii) The representatives of the medical profession on the Governing Body of such private hospital should be elected by a meeting (convened by the B.M.A. Division(s) in which the hospital is situated) to which all medical practitioners residing in the area served by the hospital have been invited.

(iii) There should be a Medical Advisory Committee which should consist of the medical members of the Governing Body of the hospital together with an equal number of medical practitioners elected by a meeting (convened by the B.M.A. Division(s) in which the hospital is situated) to which all medical practitioners residing in the area served by the hospital have been invited.

(iv) The Medical Advisory Committee should consider in the first instance all questions of a professional or medical nature and should advise the Governing Body upon the selection of all resident medical officers.

NOTE.—Attention is drawn to the Association's Policy with regard to Contributory Schemes for Private Patients (*see* Section "G" of this pamphlet).

APPENDIX VIII.

HOSPITAL POLICY AS APPLIED TO COTTAGE HOSPITALS.

PRESENT POLICY.

40. As far as possible, every patient in a cottage hospital should have the right to be attended by his usual medical attendant. He should be responsible to his medical attendant for fees in the same way as he would be outside the hospital.

41. The previous provisions contained in this report are also applicable to cottage hospitals.

SUGGESTED AMENDMENTS.

40. Membership of the medical staff of a cottage hospital should be open to all practitioners who serve the district from which the cottage hospital draws its patients.

41. Every patient in a cottage hospital should have the right to be attended by his usual medical attendant. He should be responsible to his medical attendant for fees in the same way as he would be outside the hospital. (*Slight variation of existing para.* 40.)

42. When a cottage hospital has an unrestricted staff and receives part of its income from a contributory scheme, there are two methods by which the services rendered to contributing members by the medical staff may be recognised:—

(a) by limiting the benefits of contributions to maintenance and nursing only, treatment fees being made a matter for arrangement between the patient and medical attendant; or

(b) where private fees cannot be arranged, either by an agreed honorarium, or by a percentage of all such payments being passed into a Medical Staff Fund.

43. So long as the policy expressed in paragraph 40 is not in active force, and the medical staff is a restricted one, the recognition of the services of the medical staff, whatever class of patient treated, should correspond with the method outlined in the case of the medical staff in a general voluntary hospital.

APPENDIX IX.

MODEL CONTRIBUTORY SCHEME FOR HOSPITAL BENEFIT.

OBJECT.

The.....Contributory Scheme for Hospital Benefit enables wage earners and others within definite income limits by means of an organised system of regular contributions, to give assistance to the.....hospital(s) in return for which contributing members will be relieved, together with their dependants, from all hospital charges when receiving hospital treatment. Benefit does not include the provision of treatment for which the State or Local Authority is responsible.

THE SCHEME IN ITS RELATION TO THE HOSPITAL(S) IN THE AREA.

The scheme is organised by a Committee which is entirely independent of the hospital(s) in the area as it is inadvisable that any hospital should undertake any insurance risk, the acceptance of which would prejudice the primary consideration in the admission of a patient to hospital, viz., the suitability of the case for admission on medical grounds, and might render the hospitals liable to meet outlays for which there was no financial provision and consequently endanger the purely charitable funds of the hospitals.

PAYMENTS TO HOSPITALS.

The Committee of the scheme undertakes to pay to the hospital(s) the sum of.. ..... per week for each of its contributing members treated in hospital as an in-patient, and a definite amount in respect of each contributing member treated in the out patient and special departments of the hospital. Payments to the hospitals will be based upon a tariff of fees agreed between the Contributory Scheme Committee and the hospitals concerned, such fees making full allowance for provision of hospital accommodation, maintenance of the patient and financial recognition of the services of the medical staffs unless such services are otherwise recognised.

ELIGIBILITY FOR MEMBERSHIP.

All persons, whether insured under the National Health Insurance Acts or not, whose income from all sources does not exceed the limits of the following scale, are eligible for hospital benefit under this scheme, the hospital reserving its right to refuse admission.

CLASS I.—*Limit of Income* £200 *or* £4 *a week.*

(a) Single persons over 16 years of age.

(b) Widow or widower without children under 16 years of age.

CLASS II.—*Limit of Income* £250 *or* £5 *a week.*

(a) Married couples without children under 16 years of age.

(b) Persons with one dependant under 16 years of age.

CLASS III.—*Limit of Income* £300 *or* £6 *a week.*

(a) Married couples with a child or children under 16 years of age.

(b) Persons with more than one dependant under 16 years of age.

CONDITION OF ADMISSION TO HOSPITAL.

The primary consideration in the admission of a patient to a hospital will be the suitability of the case on medical grounds.

The ordinary hospital routine of admission, transference and discharge of patients will apply and under no circumstances will preferential treatment be given to patients admitted to hospital under this scheme. No patient will be admitted without a recommendation from an attending practitioner except in the case of emergency.

CONTRIBUTIONS.

Each contributing member will be asked to pay.....per week, or if paid in advance.....per annum, and for such payments the contributing members, together with their wives, children under 16 years of age and brothers and sisters (under 16 years of age), parents and grandparents, living with and dependent on the contributing member, when accepted for treatment by a hospital will be relieved from making any payments to the hospital, from enquiries at the hospital as to means, from contributing towards the cost of maintenance, treatment, etc., and from any charges in the out-patient or special departments.

A contributing member not in receipt of wages will not be required to keep up his contributions for any period during which he is an in-patient in the hospital.

A contributing member must have paid contributions for a period of three months before he becomes entitled to any benefit under the scheme.

APPENDIX X.

MEMORANDUM ON THE INTERPRETATION OF THE HOSPITAL POLICY OF THE BRITISH MEDICAL ASSOCIATION IN CONNECTION WITH RADIOLOGICAL SERVICES.

1. A hospital receiving charitable contributions should not manage its radiological department so as to make a profit for the hospital by the exploitation of the professional services of the visiting radiologists.

2. The classification of patients shall be that of the British Medical Association's Hospital Policy, but for radiological services it is recognised there will be exceptional patients for whom specially expensive examination and treatment is necessary and for whom the income limits shall not be restrictive.

Free Patients. Those certified by the almoner or other officer of the hospital as unable to contribute in any way towards their maintenance and medical treatment; and for whom hospital benefit is provided by the gratuitious contributions placed at the discretion of the hospital managers and by the gratuitous services of the honorary medical staffs.

Aided Patients. Those certified by the almoner or other officer of the hospital as unable to contribute towards their maintenance and treatment an amount which brings them within the category of tariff patients.

Tariff Patients. Those paying or for whom is paid a fixed tariff sum which covers the whole maintenance charges borne by the hospital together with an agreed addition for the remuneration of the visiting medical staff.

This group should include, with others, those for whom payment is made (a) by public authorities, (b) by approved societies, (c) by employers of labour, (d) by insurance companies, (e) by other bodies, or (f) under any contributory scheme.

Private Patients. Persons whose income is above that laid down in the scale for tariff patients.

3. A hospital should require payment of fees from patients attending for radiological services except from those who are members of a contributory scheme which provides such services or from those who come within the category of "Free Patients." An agreed share of such fees, or an agreed honorarium, should be placed at the disposal of the medical staff.

4. A hospital may on the advice of the visiting radiologist arrange a schedule of modified charges for radiological services for patients within the scale of income limits, and based upon an average of one-half the fees commonly charged for similar private work in the district; but the schedule so arranged should not be published or exhibited publicly.

5. A hospital situated in a district where there are qualified medical practitioners carrying on in private the practice of radiology should not provide radiological services for any patient able to pay private fees for such services.

6. A hospital in a district where there is no other radiologist than the radiologist to the hospital may allow this officer to receive directly from private practitioners private patients who shall pay fees not less than those charged in private for similar cases in similar districts, and the radiologist should receive not less than two-thirds of the fees so paid.

7. Radiological services for statutory authorities (*e.g.*, Ministry of Health, National Health Insurance, Municipal Bodies, etc.) should ordinarily be arranged to be supplied in private by private practitioners. Where such arrangements must be made with a hospital the fees payable for the services shall be upon a scale made upon the advice of the visiting radiologist.

8. The normal approach to the radiologist is through the medical officers of other departments of the hospital, but in exceptional circumstances cases may be referred direct to the radiologist by private practitioners.

(Case sheets and records of patients treated in hospitals, including X-Ray Plates and Prints, should remain in the custody of the hospital; they must be regarded as confidential documents, and access to them allowed solely to the members of the visiting staff of the hospital.)

9. The hospital almoner or other proper officer should certify the suitability of patients for admission and should assess and collect all payments from patients, but the right should be reserved to the visiting radiologist to receive direct the fees for medical services to private patients.

10. Fees for services to patients in pay beds should be paid to the visiting radiologist in each individual case according to the service rendered, less an agreed proportion to the hospital to meet costs.

11. The remuneration of a visiting radiologist to a municipal hospital should be based upon paragraphs 15 and 16 of the Association's Policy on the Utilisation of Poor Law Hospitals for Civil Needs.

APPENDIX XI.

REPORT ON ENCROACHMENTS ON THE SPHERE OF PRIVATE PRACTICE.

1. The following report is the result of the consideration by the Council of the following Minutes of the A.R.M., 1927, all of which were referred by the meeting to the Council for consideration and report.

REFERENCE TO THE COUNCIL.

Minute 101. Proposed by the Council; Amendment by East Norfolk, and.

Resolved: That the arrangements laid down in the British Medical Association's scheme for school children and Maternity and Child Welfare Clinics should apply equally in regard to Orthopædic Clinics, but that efforts should be made to secure that a more stringent scrutiny be exercised in deciding which cases are, or are not necessitous, than has been done under comparable schemes for medical examination and treatment by education authorities.

Minute 163. Proposed by Brighton, and

Resolved: That the Representative Body, viewing with considerable concern the insidious inroads continually being made on private medical practice under the auspices of the State, voluntary bodies and others, and being of opinion that this is not only detrimental to the interests of the individual members of the medical profession, but ultimately to all classes in the community, instructs the Council to watch all such developments and actively to interest itself in safeguarding private practice amongst all groups in the medical profession and to develop through the Branches and Divisions closer co-operation with the local medical profession for that purpose.

Minute 166. Proposed by Tunbridge Wells; amended, and

Resolved: That the Representative Body views with anxiety the increasing tendency to transfer the treatment of many diseases and conditions to whole-time medical officers as being detrimental to the public health, and refers to the Council the consideration of the general adoption of the following principles:—

(1) The function of the health authority should be confined as much as possible to the prevention of disease.

(2) The work of the whole-time officer should be confined to administration, inspection, institutional, or consultative work.

(3) Health visitors and nurses should be definitely responsible to a local practitioner for patients dealt with by them, including expectant mothers.

Minute 220.—Resolved: That in view of the inroads being made into private medical practice by the contributory schemes which are springing up all over the country, the Representative Body refers to the Council for its consideration the following proposition by Brighton:—

(a) That members of a contributory scheme should be regarded no longer as objects of charity, and therefore that the full cost of benefits offered should be covered by the premiums, with or without supplementary payments, paid by or for the members, and

(b) that the time has come to express the policy of the Association concisely in certain cardinal principles as set out below, and instructs the Council actively to engage itself during the coming year by means of conferences with committees of such schemes, hospital authorities, staffs of hospitals, Branches and Divisions, and otherwise with a view to securing their general adoption:—

(i) That the income limit for membership of a contributory scheme should not exceed the maximum scale as it appears in the Hospital Policy of the Association.

(ii) That so far as is possible and consistent with the best interests of the members, arrangements for consultative or specialist services should be made with private practitioners rather than with a voluntary or cottage hospital.

(iii) That for this purpose (a) there should be free choice of private practitioner by member and of member by private practitioner; and (b) the method and amount of remuneration should be determined by the local medical profession.

(iv) That except in emergency a member should be admitted to benefit only upon the introduction of the attending practitioner.

(v) That recognition should be made of the services of the medical staff of the hospital attending members not by a percentage of the money received by the hospital from a contributory scheme, but by a method and amount determined by the local medical profession.

(In order to assist in determining the method and amount of remuneration to be asked for the respective specialist services, the local medical profession should consider:—

(i) payment for work done on a tariff of fees; (ii) payment on a session basis; (iii) payment by an amount to be determined annually or for a period of years; (iv) payment by a combination of two or more of the above ways.)

1 (a). It is assumed throughout the report that there is a sphere of medical practice which naturally belongs to, because it is best provided by, private practitioners, general and special, as such. The workers in this sphere may be generally described as dealing with *individuals*, either those who are sick and require treatment or those who desire to know how to maintain their health. The private practitioner would appear to be the best equipped for these services, first because from the nature of his life work he may be described as a specialist in dealing with the individual with whom in his daily practice he comes into a particularly intimate and confidential relationship; secondly, because the fact that he is chosen by the individual, puts the practitioner in a psychological relationship with the patient which greatly enhances the practitioner's power of dealing with both the patient and the disease. There is a further point of great importance, namely, that the attempt to provide for himself a practitioner, rather than seek the services of one provided and chosen for him by others, enhances the self respect of the individual—no small gain from the national point of view. This attempt at differentiation must not be regarded as depreciating the work of any class of practitioner, for the Council is anxious in this report, as always, to emphasise the essential unity of the profession and the need of the public for the services of all sections, and to discover and encourage all possible means of promoting inter-action and co-operation between all those who give medical services to the community, whether in a private or a public capacity.

PART I.

RELATING TO THE ACTIVITIES OF LOCAL AUTHORITIES.

2. This part of the report was issued in a draft form in the *B.M.J.* Supplement of 3rd November, 1928. In that form it was the work of the Private Practice Committee, the Council having come to the conclusion that on the whole it would be better to issue it without emendation and await the comments of the Divisions before issuing it in its final form for discussion in the Representative Meeting at Manchester. The wisdom of that course has been vindicated by the amount of interest that has been shown and the unusual amount of really helpful criticism that has been evoked.

3. Of the 205 Divisions in England, Scotland, Ireland and Wales, replies had been received, by 23rd January, from 113. Of these, 37 approved the draft report without emendation; and 52 (14 of which are among the 37 which approved the report as a whole) forwarded comments in connection with the report generally. A number of Divisions approved individual recommendations and commented on others.

4. Guided by these comments and criticisms the Council has amended paragraphs 2, 12, 14, 16 and 19 of the Draft Report which become in this Report paragraphs 2, 16, 18, 20 and 23 respectively; has added a new paragraph No. 24; and has recast the Recommendations.

5. There are now three Appendices to the Report:—

(A) Report by Medical Secretary on Investigation into the operation of Maternity and Child Welfare Centres and School Clinics in certain areas in England;

Sub-Appendix: Cases attending Minor Ailments and Child Welfare Centres in England (these are as they appeared in the Draft Report);

(B) Report by Medical Secretary on Investigation into the operation of Maternity and Child Welfare Centres and School Clinics in certain areas in Scotland (this is new);

(C) Report of Conference, 1922-23, of Representatives of the British Medical Association and Society of Medical Officers of Health, on the policy of the Association and Society as to Public Health Medical Services.

6. This last-named report is reproduced not only to remind the Divisions, but, also certain critics on the Public Health Service side, of the work which has previously been done on this question. It will be noted that some parts of the present Report are largely a restatement and extension of findings previously agreed between the Association as representing all classes of practitioners and the Society of Medical Officers of Health as representing specially those practitioners engaged in the Public Health Service.

NATURE OF WORK UNDERTAKEN BY LOCAL AUTHORITIES.

7. The Council has carefully considered the information before it, as to the nature of the work done at the School Clinics and Maternity and Child Welfare Centres, and is of opinion that the local authorities are amply justified in undertaking this work, leaving aside for the moment the question as to how and by whom the work should be done. The necessity for attending to the health of the persons concerned is now obvious to all and especially to members of the medical profession. Moreover, it seems plain that prior to the inauguration of these centres the kind of treatment now given was either not being given at all or was provided to a very inadequate extent. This is no reflection on the medical profession. It is accounted for mainly by the economic factor which causes the working classes, or at any rate large sections of them, to be very reluctant to incur doctors' bills for ailments which either appear to them to be trivial (such as contagious skin diseases) or for defects which they either do not recognise at all or which require specialist treatment which they feel they cannot afford (*e.g.*, tonsils and adenoids).

POSSIBLE METHODS BY WHICH THIS WORK COULD BE DONE.

8. There is in fact a gap in the provision of medical treatment for the working classes which the Association has recognised and which it has previously suggested might be stopped by one or other of two methods. It is admitted that the dependants of insured persons have not the access to medical treatment which is available for the insured person. The Association has proposed that this hiatus should be filled either by the extension of the National Health Insurance Acts to cover the dependants of certain of the insured population or, failing this, by the setting up in areas that desire it of public medical services provided and controlled by the profession itself. The first of these suggested methods seems for the time being to be out of the range of practical politics, and the second method, which depends entirely on the initiative of the medical profession, has not been adopted by the profession to such an extent as to justify the Association in putting it forward seriously as a substitute for State health insurance of the dependants.

9. Moreover, it is to be noted that even if either of these two methods were available throughout the country they would not cover all the services now given at the centres. No public medical service known to the Council provides treatment for tonsils and adenoids, for eye or dental defects, for X-ray treatment of ringworm, or for the treatment of ear defects. Nor would the National Health Insurance system, if extended in its present form, make such provision.

COLLECTIVE OR INDIVIDUAL PROVISION?

10. If it be admitted that the work done by the centres is necessary, the question arises whether it needs to be done collectively at centres or whether it could not be done equally well by the individual doctor at his surgery. The Council is of opinion that there are undoubtedly kinds of medical work which can best be done at centres. At such places certain appliances and facilities and, above all, nursing assistance, can be better employed, both to the personal advantage of the individual patient and to the economical advantage of the community. The examination and treatment of refraction errors, the enucleation of tonsils and adenoids, the X-ray treatment of ringworm, the ionisation treatment of running ears, seem to come in this category. The contagious skin diseases, the small septic wounds and the cleansing of verminous heads, would also seem to be best dealt with collectively—not because they could not be done by the private practitioner but (apart from the fact that these cases would largely never be brought to him if they had to be paid for) because they are most quickly and most effectively treated where trained nursing service is available under the direction of a medical practitioner. In scattered areas the services of the local nursing association are sometimes used as an adjunct to the employment of private medical practitioners in their own surgeries or elsewhere, but, speaking generally, the kinds of treatment dealt with in this paragraph appear to the Council to be eminently suitable for treatment at a centre.

(A) *Maternity and Child Welfare Work.*

11. Coming now to the Maternity and Child Welfare Centres the Council is unable to see that, apart from their use as educational agencies, anything that is there provided could not be done at least as well by a doctor at his own surgery, if he were willing to lay himself out for this kind of work. Advice to mothers on the feeding and general nurture of their babies is work which every doctor is trained to give and ought to be able to give, but probably few doctors in their private work can give as much attention to detail and to record keeping as the centres do. The risk is that with the growth of these centres the private practitioner may be insensibly led to believe that this is work which he cannot or ought not to do. Already in some areas the mothers are getting this impression owing to the activities of the centres. There should at any rate be no difficulty about the mothers in a position to pay—they should be encouraged by their family doctor to bring their babies to him at regular intervals so that he may examine them and advise as to feeding, clothing, etc. With his first-hand knowledge of home and working conditions the family doctor would seem to have a great advantage over the centre if he cares to use it.

12. It must not be forgotten that the Maternity and Child Welfare Centres of the best type provide a good deal of useful instruction in mothercraft by specially qualified nurses. This is excellent preventive work much of which cannot be done by the doctor. The value of it is being increasingly appreciated even by persons able and willing to go to their family doctor for medical advice and treatment, and it seems to the Council that nothing should be done to disturb activities of this kind. There will probably always be room for the Maternity and Child Welfare Centres for really necessitous persons even if the giving of this service, in so far as it is a medical service, were cultivated and given by the private practitioner to all who could provide it for themselves either by means of private fees, or by public medical services, or by extension of National Health Insurance. If this be the case the centres could continue to be used for that part of the work, mainly educational in character, which is best done at a common centre. The Council is, however, firmly of opinion that much could be done to lessen, quite legitimately, the clientele of the centres as at present constituted, if the family doctor would do all in his power to convince his patients that not only is he willing but is able to provide for them all the really medical services that they expect at the centre, and more, because of his personal knowledge of them and their home conditions.

(B) *Ante-Natal Work.*

13. The Ante-Natal Clinics are a comparatively new development and therefore should receive the special attention of the profession, if there is a serious intention to provide for public medical needs in some way other than the clinic. The public is at the present time deeply concerned in the prevention of maternal mortality and it is generally agreed that ante-natal supervision of all expectant mothers might sensibly lessen the mortality rate. To allow this work to pass without protest into the hands of Ante-Natal Clinics would seem to the Council to be a fatal confession of incapacity and lack of initiative on the part of the private practitioner. It is true that a large percentage of the midwifery of the country is now being done by the midwife, and the practitioner generally sees nothing of these expectant mothers unless he is called in by the midwife in one of the emergencies provided for by the rules of the C.M.B. But, leaving these for the moment on one side, it is the bounden duty of the practitioner to encourage the patients who do engage him for their confinements to look to *him* for their ante-natal supervision. Women insured under the National Health Insurance system are, indeed, entitled to this supervision. But there seems no reason why the others who are in a position to engage a doctor for their confinement should not be encouraged to come as a matter of course to their doctor for the advice their poorer neighbours may have to receive at the centres. The Association it will be remembered in its evidence before the Royal Commission on National Health Insurance advised an extension of the medical service under that system which would supply a doctor and a nurse or midwife to all insured women and the wives of insured men. Such an organised service would, of course, guarantee to all concerned full ante-natal supervision and would eliminate the need for Ante-Natal Clinics, for there is nothing medical done there that cannot be equally well done in the doctor's consulting room. The Council is of opinion that the recently aroused interest of the public in the question of maternal mortality should be used to impress on the Government, through the Departmental Committee on the training and employment of midwives, the necessity for the adoption of the scheme favoured by the Association or some similar plan. In the meantime the Council would suggest that a great deal could be done by instructing midwives to act in accordance with the Rules of the Central Midwives Board (Rule E 20) to call in a doctor "in all cases of illness of patient or child or of any abnormality occurring during pregnancy," instead of, as at present, recommending the patients to go to the ante-natal clinic. As in many of these

cases a doctor would probably be required at the confinement there is a great deal to be said in favour of getting that doctor interested in the case beforehand.

14. The Council has considered a number of the record forms which are kept in respect of centres and clinics run under the ægis of local authorities and considers that these forms do not place on the medical officers concerned any undue work and that the work involved in filling up these forms is not of sufficient volume to deter private practitioners from undertaking work at these centres and clinics. The Council also understands that much of the routine work in connection with the filling of these forms is done by clerks and nurses employed by the local authority.

15. There is a growing and welcome tendency on the part of local authorities to provide institutional treatment for confinement cases and this should be encouraged. And there seems no reason why the private practitioner should not (if he so desires) in most cases follow his patient into the maternity home. Where she is able to pay his fee she should be allowed to select the doctor she wants. Where she cannot pay the fee there seems no reason why she should not have the same freedom to select her doctor that she would have if she were confined at home and the midwife had recommended the calling in of a doctor. In that case he would be paid for by the local authority which has a right to recover the fee if possible, and the same thing should apply to cases in the maternity home—at any rate in those homes which are not large enough to employ a resident medical officer.

16. It is held by many that the work of medical inspection and also of the clinics has actually increased the work of the private practitioner. Probably this is so. Where the centres are carried out on proper lines many children and mothers are undoubtedly recommended to see their family doctor, and do so, who might never apply to him if they had not been so advised. But whether the total volume of medical work done by the private practitioner has been increased or not since the inauguration of the various centres and clinics, it has to be admitted that many of the preventive activities of these institutions are such that they could well be undertaken by private practitioners. It thus remains a fact that these institutions have encroached on the *sphere* of private practice. How far is this necessary?

PERSONNEL OF CENTRES—WHOLE-TIME OR PART-TIME DOCTORS?

17. The Council has already stated its opinion that certain kinds of work are more suitably and more economically done at centres. How far could and ought that centre work to be done by the local practitioners and how far is the employment of whole-time officials to the public advantage? As will be seen from the Medical Secretary's Report (Appendix A) there are two schools of thought on this subject each of which is entitled to serious attention.

18. The advocates of the employment of whole-time officers seem to the Council to rely mainly on the administrative advantages, and these may at once be admitted. They are summarized in para. 35 of the Medical Secretary's report. It is clear that the task of the medical officer of health may be less difficult if he has under him a staff of officers whose sole occupation is the work of the local authority, whose punctuality in attending to their duties can be more easily enforced, and who can more easily be employed in other branches of the health work of the authority in the absence of another officer. It seems also to be generally admitted that the whole-time officer is as a rule better at keeping records than the part-time officer. But it is significant that, as shown by the Medical Secretary's report, there are areas where the M.O.H. has convinced himself by experience that the advantages in favour of the part-time officer outweigh these purely administrative advantages. The testimony of a County M.O.H. in paras. 43 and 44 of the Medical Secretary's report is worthy of note, particularly as it is confirmed by other Medical Officers of Health who have given the part-time system a trial. The advantages of this method of doing the work as summarised in para. 46 of the Medical Secretary's report seem to demand the earnest consideration of all Medical Officers of Health and School Medical Officers who may have to advise their authorities on this subject

19. The Association has previously laid it down, in the agreement on this matter which was drawn up with the Society of Medical Officers of Health (Appendix C) that when private practitioners take up this work they must regard themselves as bound to give their public engagements priority. If this cannot be guaranteed the authority concerned is quite justified in using whole-time officers.

20. Points in favour of the employment of private practitioners in the work of clinics do not arise solely from theoretical considerations. They are influenced by practical experience, as emerges very clearly from the Medical Secretary's report. Though both public health medical officers and private practitioners have gone through fundamentally the same medical curriculum, and while, therefore, no comparison as to professional ability as between one class of practitioner and the other is raised, the private practitioner of comparable standing must necessarily have a wider range of clinical experience, and a more direct and intimate knowledge of the home conditions of those who seek his advice. Any experience gained at a clinic, moreover, enables the private practitioner to become more competent in the particular work undertaken thereat and so to utilise this increased experience and increased competence over the whole field of his practice, to the advantage of the general public.

21. There is a special advantage in the employment of private practitioners which has not yet received the attention it deserves. It is brought out in several places in the Medical Secretary's report. It is that the employment of the private practitioner in public medical work interests him in preventive medicine and in the public health work of the area. This seems to the Council to be a very great public gain. The public is looking more and more to the profession for guidance in preventive medicine and there is a growing appreciation of the fact that preventive and curative medicine should not be divorced. There can be no more practical way of securing these desirable ends than the employment of as many as possible of the local practitioners in the preventive work of the local authorities.

22. It is often held that the whole-time officer for treatment purposes is more economical than the part-time officer, but there is evidence that this need not necessarily be so. In paragraph 44 of the Medical Secretary's report will be noticed the opinion of one County M.O.H. that the employment of local practitioners might be more economical than the whole-time officer system because of the saving in travelling expenses. This point deserves the careful consideration of Medical Officers of Health and public authorities.

23. There is a further reason why Medical Officers of Health should consider the whole question *de novo*. Though it is eminently desirable that a sufficient variety of work should be retained within the field of the public health medical service, this is not secured where the great majority of medical officers of that service are individually restricted to relatively narrow sections of such work. It is well known that many junior medical officers in the public health service find, and must necessarily find, that their particular section constitutes a "blind alley occupation." It is rare for one of these juniors, whose occupation is entirely or mainly centre work, to get one of the higher administrative posts. In fact it is common for such officers to lament that they ever took up centre work as it seems almost necessarily to deprive them of any chance of doing the administrative work necessary to enable them to compete for the higher posts in the service. The result is that the service does not satisfy the legitimate ambitions of many who enter it. If, within the public health service much of the actual treatment of individual patients (which the Council suggests can best be done by those whose life-work is such treatment) were transferred to private practitioners, the public health service would probably require a smaller number of medical officers than would otherwise be the case, but for those who entered the service it would afford a much more advantageous and satisfactory field, and would offer greater opportunities as a career.

24. It must always be borne in mind that the settlement of public health policy and the details of health administration is the function of the local authority; that the final decision on these matters rests with the local authority subject to the guidance of the central Government Department concerned; that such decision is arrived at not only on medical grounds but after due regard has been had to closely related questions of administration and finance and other relevant considerations, and that it is the duty of the Medical Officer of Health (or School Medical Officer) to ensure that effect is given to the decisions of these authorities.

CONCLUSIONS AND RECOMMENDATIONS.

The following conclusions and recommendations have been arrived at by the Council after consideration of all the relevant factors and the comments made by Divisions on the draft Interim Report:—

I. The main sphere of the private practitioner is the giving of medical advice and treatment to individuals; the main sphere of the Public Health Medical Officer is the promotion of healthy conditions for the community.

II. There is no definite line of demarcation between these spheres, inasmuch as the presence of disease in individuals may directly or indirectly prejudice the health of other members of the community, and unhealthy conditions in the community not only facilitate the contraction of disease by the individual but also militate against recovery.

III. In each sphere there is need and opportunity for both clinical and preventive work, including in the latter the work usually described as health education and propaganda.

IV. The private practitioner and the Public Health Medical Officer are not therefore working in entirely separate fields, but each should be interested in and should associate himself, so far as possible, with the work of the other.

V. Nevertheless the general direction of services established by or under the auspices of the local authority should be entirely within the province of the Public Health Medical Officer; and equally no clinical work should be undertaken by Public Health Medical Officers which can, with due regard to administration, be as well done by private practitioners.

VI. The profession recognises the propriety of the State making, through central departments and local authorities, provision for giving medical advice and treatment, both as regards certain forms of disease which have a high communal importance, and generally to such members of the population as are unable to obtain the necessary advice and treatment for themselves. But centres or clinics established by the local authorities are parts of the public health service to which the above conditions (I to V) apply and those centres and clinics should not be developed in such a way as to militate against or interfere with suitable developments of a contributory National Health Insurance scheme for the appropriate sections of the population.

VII. The work of such clinics should therefore be primarily directed to education in the general rules of health and of hygiene; medical or surgical advice or treatment for the individual should be confined (a) to such treatment as can be actually given therein, and should not include any treatment that makes domiciliary attendance advisable or involves a stay of more than 48 hours at any clinic where beds are provided; and (b) to those patients who are unable, for some reason, to obtain treatment from a private doctor, and those who, as a result of supervisory medical work undertaken by the local authority, are discovered to be ailing, and for whose ailments treatment would not be sought unless it were provided by the local authority.

VIII. The concern of private practitioners generally is to secure the strict observance of these conditions and therefore (a) the question as to the existence of a family doctor, or of the possibility of securing one, should be raised in respect of every case attending a clinic; (b) health visitors, midwives, and other such officers should be actively discouraged from sending direct to the clinic any cases which can be dealt with privately; and (c) the actual treatment given at the clinic should be restricted to such as is absolutely necessary.

IX. Private practitioners should be encouraged to visit such clinics and to use them for the benefit of those of their patients who would thus be most appropriately provided for, and the question as to how far private practitioners can undertake, or be used in connection with, the work of the clinics should be seriously considered in each locality in conference with local practitioners, and wherever practicable all medical advice and treatment at local clinics should be given on a part-time basis by private practitioners whether it is within the sphere of general practice or whether it is of a specialist character.

*X. Where arrangements are made for the work at the clinics to be undertaken by private practitioners it must be recognised as essential that—

(a) all those practitioners who accept service at local clinics should be genuinely interested in the particular work which they undertake to do;

(b) this work, so long as the appointment is held, must be regarded as the first business of the practitioner, and not merely as something ancillary to the private practice to the exigencies of which he may allow it to give way;

(c) the practitioner must recognise that as long as he holds such an appointment he is, with reference thereto, under the administrative supervision and control of the Medical Officer of Health (or other properly appointed medical officer of the authority);

(d) there must be cordial co-operation between the administrative medical officers and the private practitioner in the discharge of the duties for which the latter has accepted responsibility;

(e) when the services to be rendered by the practitioner are of a specialist character it is reasonable to require that he shall satisfy certain criteria as to his special knowledge or experience.

XI. There are some advantages in the work of school medical inspection being done by whole-time School Medical Officers, but the question of using private practitioners for this work should also be considered by each authority.

* This has been secured in some areas by the establishment of a medical committee to which the local authority, the M.O.H., and the medical practitioners concerned refer questions for consideration.

PART II.

RELATING TO THE ACTIVITIES OF VOLUNTARY HOSPITALS, ETC.

HOSPITALS.

1. In addition to the activities of public health authorities as dealt with in Part I of this Report the hospitals also are formidable agencies of encroachment, both actual and potential, on the sphere of private practice. This was noted by the Association, particularly as regards the out-patient departments, so far back as 1908, when in the nucleus of our present Hospital Policy (Model Rules for Management of Hospitals) it was laid down that "the primary object of an out-patient department should be for consultation," and that "inability to pay for adequate treatment shall be the consideration for the admission of all patients for hospital treatment."

2. The three activities of hospital practice capable of encroachment on the sphere of private practice are (a) the out-patient and special departments, (b) contributory schemes for hospital benefit, and (c) in-patient departments. In this report the Committee deals mainly with the encroachments by out-patient and special departments, and only incidentally with those by contributory schemes and in-patient departments as these are dealt with in the report of the Council under "Hospitals."

3. The 1908 Policy it will be remarked was laid down at a time when the voluntary hospitals were really charitable institutions existing for the treatment of the *sick poor*. They now cater for the treatment of the *sick*. This increase of scope, welcomed as it must be by the medical profession if it is properly safeguarded, makes the hospitals potentially much more dangerous as agents of encroachment on the sphere of private practice. The basis of their support is much wider than it formerly was. No longer are they supported mainly by the charitable contributions of the well-to-do with equally charitable grants from Hospital Saturday or Sunday Funds. In the last report of the Central Bureau of Hospital Information it is stated that contributory schemes and various receipts for services rendered account for 45 per cent. of the total income available for maintenance; and the income from contributory schemes is steadily increasing. Voluntary hospitals are thus more and more becoming mutual benefit institutions with a natural change of attitude towards them on the part of the persons who seek their aid. A subscriber to a contributory scheme tends more and more to regard the hospital as a place at which he can get special advice and treatment for which he has paid by a system of insurance.

4. The British Medical Association has taken a very active part in pressing on the attention of the government and the public the need for the provision of more institutional and specialist treatment, under proper safeguards, and the voluntary hospitals are the centres at which this kind of treatment is naturally sought. It is no part of the policy of the Association to attempt to duplicate services already provided at hospitals—such a course would be uneconomical—or to try to prevent people from going to hospital who can best be treated there—this would be against all the traditions of the profession. But it is the duty of the medical profession to teach the public how the hospitals can most efficiently be used and why it is wrong and uneconomical to use them for purposes which can be better served by private practitioners. Equally it is the business of the Association to prevent the services of those members of the profession who serve the hospitals from being exploited unfairly. It is therefore very important that the profession should realise the new position of the hospitals, should study the developments now going on before its eyes, and should lay down not only the conditions on which the profession is prepared to continue its services to the hospitals in these new circumstances, but also the relationship which ought to exist between the hospital governing bodies and their staffs, and also between the staffs and governing bodies on the one hand and the practitioners who hold no hospital appointments on the other.

5. The pressure on hospital beds is very great and it is generally accepted that medical conditions alone should rule the admission to these beds. The out-patient department is the department most capable of abuse, as there no restriction of accommodation is involved. It has long been the usual custom for hospitals in making their annual reports, and especially in making appeals for subscriptions, to advertise with pride the growing number of patients attending their out-patient department during the year. For example, in 1927, the Royal Chest Hospital, in making an appeal for funds, reported that in 1926 there had been nearly as many out-patient attendances as in the first 35 years of the hospital's existence. The Prince of Wales Hospital in 1928 reported that its out-patients had increased the previous year by 8½ per cent.; University College Hospital in 1926 reported 224,909 out-patient attendances—"a record"; the Royal Northern Hospital in 1926 reported that its in-patients had gone down during the previous year by 79, but its out-patients had increased by 20,000 since 1924; the Windsor Hospital in 1926 reported an increase of out-patients from 807 to 1,227 in the previous year; and the Essex County Hospital in 1926 reported that 7 years previously the annual out-patient attendances were 10,000 whereas now they were 28,000. In Mr. H. P. Orde's Red Cross Report on the Voluntary Hospitals in Great Britain, excluding London, for the year 1927, he said that the total number of new out-patients was 2,907,198, a growth of 149,783, "which approximates to the normal," and very significantly, on page 10 of the Report for 1926 he says, "There is a widespread feeling . . . that in their out-patient departments the skill and energy of the specialists are largely expended on those who ought to seek elsewhere the relief they may require." As regards London the King Edward Hospital Fund Report for 1928 showed 25,000 more *out-patients* in 1927 than in 1926, and 156,000 more than in 1923. The *out-patient attendances* in London had increased by 349,000 during the year 1927. Similar figures could be quoted from hospitals in every part of the country.

6. The legitimate scope of the out-patient department may be defined as attending to emergencies, acting as a selection ground for cases which need in-patient attendance, the giving of second opinions to persons who are recommended for such and the giving of advice and treatment to people who cannot get that advice and treatment in any other way. It is recognised that there is a class, diminishing in numbers, which cannot be expected to present to the hospital a recommendation from a private practitioner. They have no private doctor and could not be expected to get one. These must be dealt with on their merits and controlled by the almoner when such an official exists. This class is not a large item in the enormous numbers of out-patients. In the teaching hospitals, the giving of instruction to students is an important additional function. It is a misuse of the subscribers' money to utilise the resources of the hospital for people who can afford to get treatment elsewhere, and an imposition on the charity of the honorary staff to utilise their services for people who might be private patients of some doctor (perhaps themselves), or to employ them in treating minor cases which could and ought to be dealt with elsewhere. No one who has intimate knowledge of an out-patient department can deny that a great many, probably the majority, of the cases dealt with are of a character with which the private practitioner is quite competent to deal. If subscribers to hospitals saw the average crowded out-patient department at work, and really understood the waste of good time and service that goes on there, probably many of them would transfer their charity elsewhere.

7. The introduction of the National Health Insurance system should have led to a considerable decrease, if not in the number of *out-patients*, certainly in the number of out-patient *attendances*. If it be granted that the out-patient department should mainly function as a consultative centre (apart from accidents and emergencies and attendance on the poorest class referred to in paragraph 6) and if it be agreed that the requirements of the Insurance Act should induce in the insurance practitioner a greater sense of his responsibility to the patients of whom he has undertaken the charge, one could understand and indeed expect an increasing demand for second opinions. But once that second opinion is given to the practitioner there should, in a large number of cases, be no excuse for the patient attending further at the out-patient department. Unfortunately there is a body of testimony from members of the staffs of large hospitals that considerable numbers of insured and other contract patients are sent to hospital out-patient departments for services well within the competence of the practitioners sending them; not for the purpose of getting a second opinion so much as in the hope that the patient will be taken off the doctor's hands. The duty of the members of the staff to refer such cases promptly back to their own doctor cannot be emphasised too strongly.

8. This out-patient question is a crucial test of the *desire* of the profession to prevent hospitals from encroaching on the sphere of private practice. If it can be shown that a large number of patients who are able to afford to pay for appropriate treatment by a private practitioner or for whom some doctor is under contract to provide, are allowed without protest to go to the out-patient departments or are even sent there direct by the practitioners under whose care they are, it is little use for doctors on or off the staff, or for the Association on their behalf, to complain that the out-patient departments encroach on the sphere of private practice. For the purpose of this enquiry private practice must be taken also to include contract practice. If a doctor undertakes to give such medical attendance as is within his capacity to certain patients or groups of patients, he is acting improperly to such patients if he sends them to the out-patient department for services which he is capable of giving. He is acting unfairly also to his own professional brethren if he encourages patients to go to hospital who are capable of paying a private fee (possibly a modified fee) to a specialist or consultant. It is unjust to members of the profession and an abuse of charitable funds either to send to hospital, or to treat at hospital, a patient who is able to pay a reasonable fee.

9. It will thus be seen that the problem would not be solved without the loyal co-operation of the profession even if all the hospitals made a rule that they would only see emergencies and cases sent on the recommendation of a doctor. Even when hospitals do insist upon having a medical recommendation this is capable of great abuse. In more than one important area where it is necessary for the patients to produce a medical recommendation it is said that if the usual doctor will not give such a recommendation the patients have no difficulty in getting another doctor who is more complaisant.

EMPLOYERS' CONTRIBUTIONS AND HOSPITAL SERVICE.

10. Another encroachment arises from a practice adopted by some large employers of labour in works and stores. These give donations or subscriptions to a hospital and then use it as the ordinary way of dealing with cases of illness occurring among their staffs. While there can be no objection to this practice if confined to cases of accident or emergency, it is an abuse if other cases be so dealt with. Charitable subscribers to hospitals, it is assumed, would so regard such a practice, as prosperous employers are not objects of charity and their employees being mainly insured persons are otherwise provided for. The way in which employers should deal with this is by arrangement with a private practitioner, but if this method be not adopted and the employers regard their contributions to the hospital as a payment for services to be rendered then the members of the hospital staff should share in the contribution.

11. The solution of this problem is in the hands of the medical profession itself to a far greater extent than it is in the hands of the lay managers of hospitals. If the members of the honorary staffs collectively made it plain to the hospital authorities that they protest against the misapplication of their time and the subscribers' money over a mass of minor cases which could be treated equally well elsewhere, or which cannot fairly be regarded as needing charitable assistance; and if the members of the medical profession outside the staffs could be depended upon to send to hospital with a recommendation only those patients who need a second opinion or special treatment, and who cannot get it except from charitable sources, this source of encroachment on private practice would be negligible and a good deal of the hospital income might be utilised for more urgent needs. There is, of course, the reciprocal duty on the part of the member of the hospital staff to report to the doctor who sends the case, either that the case is referred back to the private doctor or that it requires continuous hospital treatment.

ASSOCIATION POLICY ALREADY DECLARED.

12. The prevention of the abuse of hospitals is dealt with generally in the Annual Report of Council under "Hospitals" wherein it is proposed to amend paragraphs 16-24 of the Voluntary Hospital Policy (United Kingdom) (*see* paragraph 92 and Appendix VI of Annual Report of Council).

CONTRIBUTORY SCHEMES FOR HOSPITAL BENEFIT.

13. The question of contributory schemes is of great importance and needs some attention here. These schemes are now prevalent all over the country and the Association has laid down a policy which, if followed, would check the abuses which undoubtedly are now growing up. A contributory scheme has been defined by the Association as one to which contributions are made for which a stated or implied return is expected, and the following fundamental safeguards have been laid down:—

(a) That only persons below a definite income limit should be entitled to join a contributory scheme for hospital benefit;

(b) that (except in emergency) a contributor to a scheme should only be admitted to a hospital upon the recommendation of the attending practitioner;

(c) that recognition should be made of the services of the medical staff.

For a considerable time the Association has been trying to obtain information which will show how far these principles are being applied to the contributory schemes now existing. Up to the present date there are available particulars of 56 schemes, and of these it can be said that 31 have an income limit; 33 insist on the recommendation of the attending practitioner; and the number of hospitals (except a very few of the smaller hospitals of the cottage type) in which there is any recognition of the services of the medical staff is negligible.

14. All the evidence at the disposal of the Association seems to show that these schemes are regarded by the local practitioners as potentially dangerous, inasmuch as (1) the subscribers to the scheme regard themselves as having a right to any services provided by the hospital, and resent any restriction being placed on that right, and (2) the promoters of the scheme are much more concerned with the effect of the scheme on the finances of the hospitals than with the effect on the finances of the doctors whose living depends on private practice. *People who in the past would have expected to get their attendance from their own doctor or would have raised a modest fee for a consultant, now are inclined to go to the hospital as a matter of course.* There can be little doubt that the widespread diffusion of these schemes, unless safeguarded in accordance with the policy of the Association, is bound to divert more and more practice into the hospitals to the detriment of those practitioners, both general, consultant and specialist, who are competent to perform the services privately for which hospital service is now being demanded, and who in general are quite prepared to accommodate their private fees to the circumstances of patients.

15. But even if a contributory scheme be limited to the provision of hospital consultation or treatment at the hospital only, even if it be restricted in accordance with the three principles which the Association has laid down, there are still many consultants and specialists whose practice may be seriously affected thereby because they are not on the staff of a particular hospital. It is therefore desirable to encourage the widening of contributory schemes so that they may comply with the following paragraph of the policy of the Association:—

> 8. Where arrangements for consultations or specialist services for tariff patients are made under some contributory scheme or otherwise, such arrangements should provide that these services shall be given so far as is possible and consistent with the best interests of the patients by a private practitioner at his consulting rooms or at the patient's own home and not at the out-patient department of the voluntary hospital.

So far as is known no contributory scheme has attempted to put this arrangement into operation.

16. Contributory schemes for the middle classes should certainly contain this proviso. The Council is of opinion that the senior members of hospital staffs who are in an influential position with the governing bodies of the hospitals, and who are well qualified by experience to understand the detrimental effects likely to follow on these schemes if they are not safeguarded in the way indicated, should use their influence to secure this measure of justice to their colleagues, both on and off the hospital staff.

17. The only real solution so far as the working classes are concerned seems to be the extension of the National Health Insurance Acts to include consultant and specialist services, and this the Association has already recommended to the Royal Commission on National Health Insurance and pressed repeatedly on the Government.

Provision of Pay Beds.

18. There is an important new development in hospitals in many parts of the Kingdom in the direction of providing pay beds at fees which will suit the purses of people with modest incomes. Not only is there a demand for such accommodation, but many hospitals see in the provision of pay beds an opportunity of reducing their standing charges and adding to their incomes.

19. The profession can, of course, have no objection to the provision of up-to-date hospital treatment for any cases which are better treated in hospital than outside; in fact, the profession has been clamouring for this for years. But there are obvious dangers. In the first place patients may be admitted who could well pay for private nursing home treatment under the care of a private doctor; secondly, the governing bodies of the hospital are strongly inclined for administrative reasons to insist that only members of the staff shall treat patients admitted to beds under their control; and in consequence, there is a great likelihood of the ordinary medical attendant being cut off from the case altogether once it enters the hospital. (*Vide* Sections X, XI and XII of Hospital Policy.)

Effect of the Local Government Act, 1929.

20. The Local Government Act, 1929, transferring the Poor Law Medical Service to the County and County Borough Councils will extend the possibilities of encroachment upon private practice. Reference to this will be found in para. 125 of the Annual Report of Council.

Encroachments by Special Hospitals and Special Departments of Hospitals.

21. The recent increase in demand for X-ray examinations, pathological examinations, and physio-therapy, is likely to give rise to developments seriously injurious to those who practise these special methods. A hospital in London recently issued a pamphlet to the profession pointing out that it had a completely equipped X-ray department and the Committee of the hospital had decided to provide for examination and treatment of any part of the body. The announcement went on to say that these facilities would only be available for patients who were not eligible for hospital benefit and who were unable to pay the fees of a private radiologist. All such patients must be introduced by a medical practitioner.

22. It is obvious that unless there is strict loyalty in the profession there is here a risk of unfair competition, not only between the hospital and the specialist attached to the hospital, who might find himself doing work there for nothing or for a modified fee for which he might have been paid privately, but still more between the hospital and its officers and those private specialists not attached to a hospital. The same remarks apply to the various hospital schemes for provision of pathological examinations and also to those public health authorities which have established pathological laboratories and are offering examinations at rates with which the private pathologist cannot compete.

23. There is evidence that all the special departments of voluntary hospitals are being used by many who are in a position to pay privately for the necessary service, and still more by those for whom the local authorities have made themselves responsible. For example, the ear, nose and throat departments at some of the hospitals are being used to obtain necessary operative treatment for school children found to be suffering from enlarged tonsils and adenoids, and this, with little or no financial recognition of the services of the medical staff concerned.

24. In the same way eye cases, both of school children and insured persons and their dependants, are being dealt with at the hospitals. As regards the latter class, so far as the insured persons are concerned, when they belong to approved societies which provide ophthalmic benefit, the National Ophthalmic Treatment Board's scheme is available, and so far as their dependants are concerned the same scheme operates at a fee well within the reach of working class people who need expert refraction treatment.

25. The giving of advice and treatment in the special hospitals themselves and in the special departments in general hospitals, as in the ordinary departments, should only be for the benefit of those who cannot get such advice or treatment in any other way. In order that this position may be safeguarded it is essential that the medical staffs who are engaged in special departments should make it clear that they are not prepared to give free service simply because a person is making a weekly contribution to a contributory scheme or is sent by a public authority. The benefits promised in connection with schemes of this kind should be strictly limited so as to exclude those services for which provision within the means of the contributor is made elsewhere, and public authorities have no right to expect charity for persons for whom they are responsible.

26. The Council finds it necessary again to emphasise the fact that the remedy lies very largely with the profession itself. If the doctors attached to the staffs of hospitals offering these facilities insist upon the Policy of the Association being applied, including an income limit, and a recommendation from a private practitioner as an *essential* introduction except for the poorest persons to whom reference has already been made, and if the private practitioner regards the giving of this introduction as a very serious responsibility, hospital encroachment of all forms could be reduced to a minimum.

DOMICILIARY ATTENDANCE BY WHOLE-TIME MEDICAL OFFICERS.

27. The domiciliary attendance on poor law patients has up to the present time been given in the very large majority of areas by practitioners in private practice and the Association believes that this is the only satisfactory method. It softens to a great extent the distinction between sick poor persons who, because of their sickness have technically become paupers, and their neighbours, because the same doctor is often attending both, and it ensures that the domiciliary attendance shall be given by practitioners whose life work it is to give such attendance and not by an official to whom domiciliary attendance is a subordinate part of his work.

28. In a few areas whole-time officers have been appointed, who besides doing the domiciliary attendance on paupers, have duties in connection with the workhouse infirmary. Recently another innovation has been made which the Association regards as a retrograde step. In order to enable a local authority to find the salary which would justify it in employing a whole-time medical officer of health, in at least two cases the duties of poor law medical officer, including not only the workhouse infirmary medical service, but the domiciliary attendance on paupers, have been combined with those of medical officer of health. In spite of a strong protest by the Association these appointments have been approved by the Ministry of Health and it is evident that with the opportunities given to the County and County Borough Councils in the new Local Government Act there will occasionally be temptations to extend this system, for both kinds of work, institutional and domiciliary, will be under the control of these bodies and the easy administrative line is always to employ whole-time officers under complete control.

29. In this connection attention is drawn to the following three resolutions passed by the Representative Body, 1928:—

Minute 157. Resolved: (i) That domiciliary attendance should, in the best interests of the patients, be provided by private practitioners in the area concerned and not by a whole-time medical officer; (ii) that the adoption of the above resolution leaves unprejudiced the position of any medical officers at present holding whole-time appointments in which domiciliary attendance is one of the duties; (iii) that if there are in the area no practitioners willing to undertake the domiciliary work on suitable terms, paragraph (i) shall not apply.

Minute 158. Resolved: That there is no objection in principle to the combination in one and the same whole-time appointment of the duties of a medical officer of health and those of a poor law institutional medical officer, but the application of this principle in any individual instance must be governed by local circumstances and by the opinion of the Division or Divisions concerned.

Minute 159. Resolved: That there is no objection in principle to the combination in one and the same whole-time appointment of the duties of a medical officer of health or of a poor law institutional medical officer and those of a public vaccinator, but the application of this principle in any individual instance must be governed by local circumstances and by the opinion of the Division or Divisions concerned.

CONCLUSION.

30. There are many other relatively minor possibilities of encroachment on private practice by voluntary bodies and others which will occur to every practitioner, such as for example the recently established baby clinics for middle class people, but the Committee thinks it desirable in this report to concentrate on those encroachments which are more general and therefore more dangerous. If the general principles underlying this report, and others which have already been adopted by the Association, are applied to the newer developments, the risks to the sphere of private practice can be reduced to a minimum, but it must be obvious from this report that there are serious possibilities in the direction of the gradual sapping of the position of the private practitioner which require the utmost vigilance and loyalty on the part of the medical profession.

APPENDIX (A).

REPORT BY MEDICAL SECRETARY ON INVESTIGATION INTO THE OPERATION OF MATERNITY AND CHILD WELFARE CENTRES AND SCHOOL CLINICS IN CERTAIN AREAS IN ENGLAND.

1. Before setting out on my tour of investigation I refreshed my memory with the history of the local health services particularly under inquiry, both from the point of view of the Association's connection with them, and from the point of view expressed by the Chief Medical Officer to the Ministry of Health and the Board of Education, as stated in his annual reports.

DUTIES AND POWERS OF LOCAL AUTHORITIES.

2. The present powers and duties of local authorities in respect of the establishment and maintenance of school medical services and maternity and child welfare services may be summarised as follows:—

School Medical Services.

The local authority for elementary education MUST make or otherwise secure adequate and suitable arrangements for attending to the health and physical condition of elementary school children and MUST provide for their medical inspection.

The local authority for higher education:—

(1) MUST provide for the medical inspection of children or young persons attending—
(a) secondary schools provided by them;
(b) certain other specified educational institutions;
(2) MAY, with the sanction of the Ministry of Health, make arrangements for attending to the health and physical condition of such children or young persons;
(3) MAY, on the request of the persons responsible for the management of other educational institutions, exercise the above powers in respect of children or young persons attending them.

In the exercise of these powers the local authority concerned:—

(1) MAY encourage and assist the establishment or continuance of voluntary agencies and associate with itself representatives of voluntary associations for the purpose;
(2) MUST consider how far it can avail itself of the services of private medical practitioners;
(3) MUST NOT establish a general domiciliary service of treatment by medical practitioners;
(4) MUST recover the cost or part of the cost of any medical treatment for which it provides, unless satisfied that the parents are unable to pay.

Parents are under no corresponding obligation to subject their children either to medical inspection or treatment. They can be compelled, however, to submit them to medical examination for the detection of any verminous condition, and in certain circumstances either to accept or provide necessary medical treatment. (Education Act, 1921 (Consolidated), and Children Act, 1908.)

Maternity and Child Welfare Services.

Any local authority within the meaning of the Notification of Births Acts:—

(1) MAY, for the purposes of the care of expectant mothers, nursing mothers and young children exercise any powers which a sanitary authority has under the Public Health Acts, 1875 to 1907, or the Public Health (London) Act, 1891.
(2) MAY make such arrangements as may be sanctioned by the Minister of Health for attending to the health of expectant and nursing mothers, and of children who have not attained the age of five years and are not being educated in schools recognised by the Board of Education;
(3) MAY NOT establish a general domiciliary service by medical practitioners.

In exercising such powers a local authority MUST establish a maternity and child welfare committee, which may be an existing committee of the Council or a sub-committee of an existing committee, to which all matters (other than raising a rate or borrowing money) relating to the exercise of such powers shall stand referred. Except in matters of urgency the Council MUST consider the report of this committee before exercising such powers and MAY delegate to it, with or without restrictions or conditions, any powers exercised by the Council under these Acts, other than those relating to finance. (Maternity and Child Welfare Act, 1918; Notification of Births Acts, 1907 and 1915.)

Local supervising authorities under the Midwives Acts are responsible for the general supervision of all midwives practising within their areas in accordance with the rules made by the Central Midwives Board. The authority:—

(1) MAY aid the training of midwives within or without its area and make grants for the purpose;
(2) MUST pay medical practitioners called in by midwives in cases of emergency under the rules of the Central Midwives Board the fee fixed by the Ministry of Health;
(3) MAY recover such fee from the patient or the person responsible for the patient's maintenance, unless satisfied that the person is unable to pay the fee. (Midwives Acts, 1902 to 1918.)

THE B.M.A.'s RESPONSIBILITY FOR THE ESTABLISHMENT OF MEDICAL INSPECTION AND THE TREATMENT THAT HAS FLOWED FROM IT.

3. This first point of view is very important because whatever we may think of the results of our work there is no doubt that the Association was more responsible than any other body for the institution of Medical Inspection of School Children, out of which all the services in question have grown.

4. So far back as 1888 the Association appointed a Committee to conduct an investigation into the average development and condition of brain power among children in primary schools. In 1889 that Committee presented a report on 5,440 children; and the *B.M.J.* in a leading article, July 27th, 1889, said "The Committee has done good work and has pioneered the way for medical inspection of school children." And so it proved. After a long succession of reports, collaboration with other bodies, deputations to Ministers, evidence before Royal Commissions, etc., in connection with which the Association spent a good deal of money in various investigations, the Education (Administrative Provisions) Act, 1907, was passed, imposing on Local Education Authorities the duty of providing for the medical inspection of children in elementary schools, and giving them the power (later transformed into a duty) to make arrangements for attending to their health and physical condition. The schedule for the examining doctor which was adopted by the Department was almost identical with that which had been drawn up by the Association.

5. The natural result of medical inspection, which revealed the fact that something like one half of the children inspected were in some way defective, led to a public demand for the necessary treatment to be provided—a demand in which the Association took an active part. Further, it was soon found that it was poor public policy to confine attention only to children at the age of 5 or 6, when it was clear that many of the defects were established much earlier—even in pre-natal life. Hence the giving to local authorities the power to set up Maternity and Child Welfare and Ante-Natal Centres, where, however, attendance is voluntary.

6. As a further illustration of the stimulating effect of the Association in promoting public treatment for certain diseases our efforts in connection with ophthalmia neonatorum may be mentioned. It was the report of a British Medical Association Special Committee which was largely responsible for inducing the Government to institute compulsory notification and the subsequent treatment of this disease.

THE ATTITUDE OF THE MINISTRY OF HEALTH AND BOARD OF EDUCATION.

7. These two Departments have never ceased to urge on local authorities the necessity of recognising their responsibility for finding out those persons suffering from the defects for the care of which the country had by legislation made itself responsible. The attitude of the Departments on the aspects of the questions which particularly exercise the mind of the Private Practice Committee has been consistent and has been reiterated with great force and frequency. Take, for example, this quotation from the Annual Report of the Chief Medical Officer of the Board of Education for 1912:—

> "*The Private Medical Practitioner.*
>
> It is desirable again to make clear the attitude of the Board in regard to the employment of general medical practitioners in the School Medical Service. From the commencement of the new work the Board have taken the view that in most areas the local education authorities will find that the statutory duty of medical inspection can be best undertaken by whole-time medical officers, and whilst considerable latitude has been allowed, this practice has, in fact, come to be the rule and its wisdom has been abundantly confirmed by experience. The burden of work, its character, its regularity, and its daily claims are such as require in most circumstances the whole time and thought of the officer concerned. But this fact being granted, the Board have urged that the defective child should be brought into touch with such forms or branches of medical practice as were available in the district, including the private practitioner. Thus it has come about that the School Medical Service includes the work of the general practitioner in various capacities, though always within the ambit of the organisation for the administration of which the School Medical Officer is and must be responsible. The part which the general practitioner plays must be set out thus:—
>
> (1) Medical inspection work in certain areas. There are six counties (Kent, Derbyshire, Leicestershire, Hertfordshire, Oxfordshire, and Buckinghamshire) where a large number of part-time practitioners are employed in the work of medical inspection. In several boroughs also the School Medical Officer is himself in private practice.
>
> (2) Treatment furnished in private practice. It is probably the case that most ailing school children who receive treatment are treated by the family doctor, and in many areas he is the chief or only agency of treatment.
>
> (3) Treatment provided in clinics. At the end of the school year, 1912-13, treatment at school clinics was being carried out by 194 medical men and 89 dentists; of those, 101 (including 19 dentists) were whole-time medical officers in the employ of the local education authorities; 182 (70 of whom were dentists) were part-time medical officers, engaged otherwise in medical practice in the areas. These numbers do not include ophthalmic surgeons employed exclusively in refraction work, nor any practitioners carrying out treatment on premises other than school clinics.
>
> (4) Treatment at upwards of 300 hospitals staffed wholly or partly by general practitioners or medical or surgical specialists not in the public service.
>
> (5) Treatment under the Poor-law. A small amount of medical treatment has been provided by the Poor-law Medical Officers, who are generally private practitioners.
>
> In addition there is the work done by private practitioners as Medical Officers of Training Colleges, of Special Schools, and as nominated under the Elementary School Teachers (Superannuation) Act.
>
> It is obvious that for the purposes of good administration it is necessary to require that the school medical officer shall be held responsible for the supervision of the organisation within which the private practitioner works. He does not interfere with the actual details of medical treatment, nor does he come between the practitioner and his patient, but he is responsible for bringing the two together; he or his assistant inspects the child, in many cases he submits it to the practitioner, he provides or assists in providing for the practitioner's use facilities for diagnosis and treatment, and he re-examines the child subsequently to treatment. Finally, he is the chief officer responsible to the authority and the Board of Education."

and this from the Report for 1914:—

> "Everyone, in theory at any rate, is willing to acknowledge that it is a good thing that the ailing child should be cured of its ailment. Hesitation on the part of education authorities has been based mainly on three grounds of objection: (1) that such action would have a pauperising effect on the parent, and be destructive of the sense of parental responsibility; (2) that it would impose an unjustifiable burden on the ratepayers; (3) that it would have a detrimental effect on the legitimate practice of medical men. Experience has shown that none of these apprehensions has been justified, but that the whole tendency of medical work amongst school children has been to stimulate a sense of responsibility in the parents, by educating them in the need for safeguarding the health of the children; that the cost to the ratepayers has been relatively small in comparison with the tangible benefits resulting from treatment; and that private medical practice has not been shown to have suffered, for the sufficient reasons that the children dealt with have been those who otherwise would not have obtained treatment, and the treatment which has been provided has, in a large number of cases, been given by private medical practitioners working under the authority."

and this from the Report for 1924:—

> "*The private medical practitioner.*—Before leaving this subject there are two points to which reference should be made. Throughout the whole series of my reports I have consistently urged that in any complete scheme for the medical care of school children the services of the *general medical practitioner* should be obtained as far as possible. From the inception of the School Medical Service, the routine practice has been for the parent of the child to be informed of the defect discovered at the medical inspection, and urged to obtain the necessary treatment. This is undoubtedly the proper course to adopt, for its effect is to refer the parent not only to a doctor of his own choice, but to one whose general professional experience should give him exceptional facilities for dealing with the physical defects of children. Moreover, his treatment is mainly of a domiciliary nature, and, living in the locality, he is readily available. On the other hand, there exist various reasons which, in a large number of cases, militate against the employment of the private medical practitioner. There is often inability on the part of the parent to afford the expense, or unwillingness on the part of the doctor to provide the necessary treatment. The latter cannot afford to work for unremunerative fees and often he is not in a position to deal adequately and in detail, day by day, with the

common defects of school children—defective vision, discharging ears, carious teeth, adenoids, skin diseases and minor ailments. In either of these circumstances the parent is offered the facilities provided or made available under the authority's scheme for treatment. It has to be remembered that the defects for which the authority provide treatment are restricted in number and kind, and are often of such a nature as to preclude the possibility of their treatment by a busy private medical practitioner. Thus, while admittedly on the one hand the institution of the treatment facilities of the School Medical Service has transferred some remedial work from the sphere of the private to the official medical practitioner, there is on the other hand an abundant number of references to the private practitioner as a direct outcome of the institution of State medical inspection in the schools."

and, finally, the well-known quotation from the revised issue of the same officer's "Outline of the Practice of Preventive Medicine," published in 1926:—

"The foundation of a medical service is the medical practitioner; he is its pivot; its anchor, its instrument. The State should not take out of the hands of the medical practitioner the patient whom he is willing and competent to treat and on reasonable terms with which the patient can comply."

The Method adopted in the Investigation.

8. The Committee selected six areas in which it was desired that I should see the machinery at work. These areas comprised two counties, two county boroughs, one borough and one urban district, and they were selected because, taken together, they were believed by the British Medical Association and the Society of Medical Officers of Health to illustrate the various methods adopted throughout the country. In some the local practitioner, both general and special, is used freely in the work; in others the work is done very largely (but never altogether) by whole-time officers. In every area I was received with the utmost cordiality and was given every opportunity to see whatever I liked. In no case was any attempt made to influence me in my choice of the activities I wished to see. I made my arrangements well in advance and received from the Medical Officer of Health a full description of all the medical work done in the area and the way it is done. Having made my notes on these statements I first met the Medical Officer of Health and spent some time in eliciting his views on the points I was specially interested in. Then I asked to be taken to the centres I had chosen. At these centres I was left to talk freely to the doctors doing the work and to the patients attending. I also had interesting talks at three of the places I visited with some of the Health Visitors. And in each area, after I had made my tour, I met either the Division Executive, the Branch Council, or a meeting of the Division, and ascertained their opinions on the things I had seen and the views I had formed.

9. I kept prominent before me during the whole time the following points, which are raised in the Minutes of the A.R.M. which were referred to the Committee:—

(1) The inroads which are said to be continually made on the sphere of private practice;

(2) the alleged increasing tendency to transfer treatment to whole-time officers;

(3) the practicability or otherwise of the work of whole-time officers being confined entirely to administrative inspection, institutional or consultative work;

(4) the possibility (raised in Minute 26 of the Committee) that some of the alleged inroads may be "in the best interests of the patient and therefore deserving of support."

The Nature of the Work which is being done at the various Centres.

10. I think it is important that the Committee should get a firm grasp of the nature of this work, for I have reason to believe that few private practitioners (outside the areas in which this work is done by private practitioners) have any first-hand knowledge of the procedure. I was astounded, on asking the doctors I met at my various meetings to find that hardly any had ever been inside one of these centres.

11. I visited in all 53 centres of public medical work, divided up as follows:—

13 Maternity and Child Welfare Centres.
12 Minor Ailment Centres for treatment of school children (including diseases of eye, teeth, throat, nose and ear).
7 Hospitals (Municipal, Poor-law or Maternity).
6 Ante-Natal Centres.
5 School Medical Inspections.
3 General or Cottage Hospitals, where special work was being done for patients sent from Centres.
3 Pathological Departments.
2 Tuberculosis Dispensaries.
1 Venereal Disease Centre.
1 Nursery School (not strictly medical work).

12. At each area I visited I obtained lists of the first 20 cases attending three centres of each kind (Minor Ailments and Maternity and Child Welfare) and also several similar lists from Ante-Natal Centres. I found on analysis such a remarkable similarity between them that it will suffice if I present here one of each (*see* Sub-Appendix).

13. My visits to these centres, coupled with my remembrance of practice among working class people, and my conversations with doctors at meetings in the areas left me with certain strong impressions. First, the authorities have been abundantly justified in doing this work for the reasons (a) it is work that every doctor must agree ought to be done by somebody, and (b) it was not being done—or was being done to a miserably small extent—before the public authorities undertook it. Nobody, I think, could watch the work and see the kind of people for whom it was being done without coming to these conclusions. The work at the Minor Ailment (or School) Clinics, if one leaves out those things which the average general practitioner does not do (X-ray treatment of ringworm, refractions, tonsils and adenoids, teeth) consists very largely of work which is best done by a nurse under medical supervision. This will be seen from an analysis of 63 cases seen on one morning in one of the centres I visited:—

There were 10 dental cases; 11 refractions; 3 T. and A.	= 24
2 had suspected T.B.; 2 "probably worms"; 1 had a temperature and was referred to home doctor; 1 had nits in the head; 4 were diagnosed as "debility" and ordered cod-liver oil	= 10
27 out of the 29 left were contagious skin diseases or septic wounds, except 2 of otorrhœa, and all these required either a simple dressing, or regular attention by a nurse.	

14. That this work was not being done before the public authorities took it in hand is I think clear. The average poor parent, unless pressed, will not take the trouble to go to the expense of consulting a private doctor about many of these minor ailments. They are left to get better themselves or, if a doctor be consulted, the chances are heavily against any treatment required being properly followed up. In talking to practitioners at my meetings I found a general disposition to agree that much of the work done at the School Clinics could best be done there. Most of my audience agreed they had neither the time nor the inclination to dress small septic wounds, syringe out otorrhœas regularly, do the actual dressings for impetigo cases, etc., for the payments they were likely to get out of the class of people whose children go to clinics. Nor could they afford to keep a nurse to do it, and they agreed that in most cases the dressings, etc., would be likely to be done inefficiently by the mother.

15. What seemed to me to be a very significant piece of evidence on this point was what I saw in several places where considerable sections of the population are attended on a contract system. Here, everybody has a "family doctor" who is paid to attend the wage-earner through the insurance system and the rest of the family by a deduction from wages. One might have expected to find here that the various clinics were unnecessary or were ill-attended. On the contrary they seemed to be very popular and I was assured both by the officers of the clinics and by parents whom I interrogated that quite often cases are referred to the clinics by the family doctor to whom they are taken in the first place. I take this to be due to a realisation by the doctors in question that the work is on the whole better done at a common centre where the services of a nurse are available. The Medical Officer of Health for Swindon reports that over half the population is provided for by the Great Western Railway medical scheme which employs a whole-time medical staff. Not only do the members of that staff make full use of the municipal schemes but the private practitioners also are very willing to hand over their patients to the clinics for the services there provided. The general tendency in Swindon is for the municipal service to do everything connected with children up to the age of 16, excluding acute diseases. "Practically every school child requiring minor ailment treatment, throat, nose, ear or eye treatment or orthopædics is attended to by the public health department (which gets the work done or does it itself) and with less than half a dozen exceptions a year every child born in Swindon attends the child welfare clinics, ... theoretically the existence of the Great Western Railway Medical Fund should render a great deal of the municipal clinical work unnecessary, though as I have pointed out, exactly the reverse comes about in practice."

16. The proof that the finding out and treatment of these defects was not being done before the establishment of these school clinics is also evident in the statistics of school inspection. The lowest estimate I have seen of children found on medical inspection to have some physical defect or other is 20 per cent., and in many areas it is much higher. In London in 1918 the percentage of children found to be needing treatment of some kind was 44 per cent.

17. These remarks apply with equal force to the case of the children under school age. The School Medical Officer for London, in his Report for last year, urging the necessity for getting these children earlier, declared that the School Medical Service was "the receiver of damaged goods," and the Consultant Ophthalmologist in one large area said in his Report that in many of the cases the time for effective curative treatment has passed before school age. But indeed it is unnecessary to labour the point to a medical audience, that many of the defects found on first inspection at school might be detected and treated earlier.

18. Personal inspection of the Maternity and Child Welfare Centres brings sharply home to one the necessity of the work. Take Table No. I in the Sub-Appendix. It shows 9 children, of whom 3 were healthy and were brought for advice as to how to keep well; six were defective, of whom one was under family doctor; 2 were referred to dentist; and the others needed advice as to feeding, etc. Of the 11 mothers, 2 were referred to family doctor; 4 were definitely midwives' cases; 2 came to ascertain if they were pregnant (1 ascertained that these intended to engage midwives); and the others came for general advice. They were all of a poor class and one thing impressed me at nearly all these centres. The waiting accommodation is generally such that people who can afford to go to a doctor are not attracted—it is very much like that of a hospital out-patient department, on the whole less attractive I thought, though there were some exceptions where a good deal had been done to make the place bright. And, moreover, in every case I found a strong pre-disposition on the part of the medical officers, enforced by the instruction of the Medical Officer of Health, to refer suitable cases to own doctor when there was one.

19. In all the places I visited I found that the idea laid down in our own report on "The value of Maternity and Child Welfare work in relation to the Reduction of Infant Mortality (1921)," namely:—

> "The primary and main object of Maternity and Child Welfare Centres should be educational, preventive and advisory: no treatment should be given for conditions which, in the absence of the Centre, would be recognised as calling for the attendance of a medical practitioner: it is against the best interests of the centres to encourage women to go to the centre for what they can *get* rather than for what they can learn"

was apparently the ruling principle. In one area, where economic conditions are very bad and a good deal of free or practically free milk and other foods has perforce to be dispensed, the medical officers recognised that this temporary need was tending to obscure the real purpose of the centres. But in present conditions they are helpless in the matter. And in another area, where the local authority used to be particularly active in encouraging the growth of municipal medical treatment, a very considerable change had occurred in the last few years. A dispensary at one centre which formerly held a first-class collection of drugs is now mainly used for storage of artificial foods, and the drugs now used had been reduced to a minimum, not without a good deal of opposition on the part of a section of the authority. The only drugs I saw given were an occasional grey powder, cod-liver oil, and external remedies for the contagious skin diseases, and, very occasionally, a simple cough mixture. In case anyone of a suspicious nature should think the usual routine was altered because I was there I may say that in every centre I looked at the past records of the cases under inspection. Some of the officers in charge of these centres frankly said they would prefer to be allowed to give full out-patient treatment because they knew that many of the children and mothers who were recommended to go to their own doctor for further treatment would not do so.

20. The work at the Ante-Natal Clinics is well exemplified in Table III in the Sub-Appendix. Of 20 cases, 11 were sent in directly by midwives; 1 had engaged a doctor: 2 others were advised to do so (under a local insurance scheme whereby on payment of 5s. the presence of a doctor at confinement is assured if needed and without any further expense to patient); 3 were sent to hospital; 4 came to know if they were pregnant. In each case, where necessary, a note was sent to doctor or midwife, as the case might require. I asked at each centre whether there was much co-operation with the local doctors and found that there was a good deal of variety. At one centre the doctor told me she often had cases sent for a second opinion and cases were sometimes referred by doctors of women who were believed to be unable to pay a doctor's fee at confinement, or who, in the opinion of the doctor, required regular supervision for which they could not pay, or needed hospital treatment which the clinic officer could readily obtain. I found a real disposition on the part of all the doctors at the ante-natal centres I visited (all whole-time officers) to co-operate as far as they could with the private practitioner. They told me that under strict instruction they always advised women who were abnormal to go to their doctor and sent a note to the doctor concerned. In more than one area I was told that this latter courtesy did not seem to be appreciated.

21. There is an increasing desire on the part of the women who attend these centres to have their confinement in an institution and one is not surprised when one hears of the average income and the total cost of a confinement at home, not to speak of the frequent impossibility of having it at home under decent conditions. Take, for example, a woman I interrogated in a London suburban area (selected quite by chance) whose husband was a labourer—average *gross* weekly income over last 4 weeks £2 17s. 9d.; after deduction of rent, insurance, and travelling expenses of husband to his work, the net income was 37s. 6d. a week. Her confinement expenses at home (leaving aside question of accommodation) would be—a doctor £3 3s. 0d., to which would have to be added 25s. to 30s. a week for a maternity help, and on the top of this there would be increased laundry expenses and probably increased household expenses due to lack of her supervision. Even if she had a midwife the cost would only be about 30s. less. She was admitted to the local maternity hospital for a payment of 25s. and after paying even this reduced sum she said she would find it hard work to meet the additional household expenditure.

22. At another centre I examined a list of 10 applications for admission to the Maternity Hospital; 2 were admitted because of previous difficult confinements, the rest would probably be admitted if accommodation served, mainly because of inadequate accommodation at home, *e.g.*, 4 persons living in 2 rooms; no extra bedding.

23. As regards Tuberculosis Dispensary work I heard no complaint from the doctors at the meetings I had. There seems to be a general acceptance of the fact that tuberculosis among the working classes is better dealt with through the medium of the Tuberculosis Officer than it was before his creation. Indeed, in the Dispensaries I visited I was told that there is a growing disposition on the part of the doctors to send their cases earlier to the Dispensary and actively help in the searching out of contacts. I was informed that with the exception of contacts who are invited to go for examination, no person is seen except on a doctor's recommendation, and if any suspicious symptoms are found in any of the contacts examined, the private doctor is at once informed.

24. At the only Venereal Disease Clinic I visited I enquired whether there was any disposition on the part of the doctors to object to cases going to the clinic. The treatment of these diseases used to be a fairly lucrative item in the practices of many doctors, particularly in seafaring areas, in one of which this clinic was situated. The Venereal Disease Officer said there was little or no difficulty; that a large number of his patients would in old times have been treated by quacks, or by chemists, or at hospital; and that generally speaking he had the hearty co-operation of the local doctors. The reason he thought was very creditable to the profession, for they had realised that the opportunities for modern radical treatment of these diseases at clinics are much superior to those obtainable in almost any private house. The treatment of gonorrhœa takes up a great deal of time for which few can pay adequately. It is also realised that the modern treatment of syphilis requires special skill and training and is not without risks to the patient.

25. I was much struck with the elaborate arrangements prevailing in all the areas I visited for enquiring into the economic conditions of people applying for anything beyond the routine inspection, advice and dressings given at the centres. Speaking generally, no enquiries are made as regards the children attending the minor ailment clinics, who generally go on the recommendation of the School Medical Inspector or the School Nurse. If they only require the simple things provided, *e.g.*, treatment of a septic wound or of a contagious skin disease, no charge is made—though in at least one area the doctors (part-time officers) have full liberty to send away anybody they think could afford to pay—a privilege which I was told is very seldom used. If, however, spectacles are required, or X-rays for treatment of ringworm, or tonsils and adenoids require to be removed, careful enquiries are made as to capacity to pay and an assessment is made and followed up—the strictness of the following up I should imagine varies very much from area to area, in accordance with the state of employment and political colour of the majority on the local authority.

26. In every area I visited it seemed to me that a genuine attempt was made (before giving anything except treatment

for really minor ailments) to get the parent to consult the private doctor. In every area there is a form which is sent to the parents, of which the following is a sample :—

"To the parent or guardian of .....

Your child is in urgent need of operative treatment for tonsils and adenoids (or is reported to be suffering from defective eyesight, etc.). You are recommended to consult your own doctor with a view to securing the necessary treatment, or if he prefers it, arrangements can be made for the operation through the Education Committee's Scheme." (Then follow particulars which the parent is obliged to give before he can use the Scheme.)

27. The claim that is made by all the Medical Officers of Health of the areas I visited, by many correspondents, and by Sir George Newman must not be overlooked. It is claimed that all this searching out of defective children, the reporting of their defects to parents, and the advice given to mothers about themselves and their babies, has led to an increased demand for medical attendance from the private doctor. This claim, when put before an audience of general practitioners, is liable to be received with something less than acceptance. But there can be no doubt the work of the centres has led to a great deal of work being put in the way of specialists of various kinds—work which was formerly not done or if done was mainly done gratuitously at hospitals. And even as regards the other work, the notices sent to parents as regards their children must have made many who would otherwise not have been warned, seek the advice of their family doctor. And it must be remembered that at most school medical inspections it is the rule for the parent to be there with the child, and advice and warnings as regards the general health of the child are frequently given and must often lead to action on the part of the parent, as regards complaints which are not dealt with at the clinic. Moreover, I never visited one Maternity and Child Welfare Centre without hearing some woman strongly advised to see her family doctor about something or other.

28. I summarise this part of my report as follows :—

(a) The work of the School Clinics is largely made up of preventive advice and the treatment of really minor ailments;

(b) it is work which is, generally speaking, not catered for by the general practitioner, partly because much of it needs mainly the services of a nurse, who is not generally at his disposal, and who in any case could only be used to economic advantage if the patients were collected at a centre; partly for reasons of an economic nature—the great majority of the cases I saw were such as would be very unlikely to lead the parents to incur a doctor's bill;

(c) the same remarks apply to a certain extent to the Maternity and Child Welfare Centres and Ante-Natal Clinics. I am of opinion (and I was confirmed in this by my conversations with the practitioners I met) that few doctors are catering either for the Child Welfare work or for the Ante-Natal work—partly because it is to a large extent new work which the older members of the profession were never trained to do; partly because of the economic difficulties, for even the better paid working people may well hesitate to run up a bill for regular attendance by a doctor when the patient is not really ill and when it is only, or largely, a question of preventive advice. The great majority of even educated and well to do persons have yet to learn to go to a doctor for advice when they are well, much more the kind of people the local authorities are dealing with, and most doctors have never catered for this kind of advice.

29. Before leaving this part of the subject it is necessary to state that in every area when I met the general profession, complaints were made of the over keenness of Health Visitors, leading them to persuade people to go to centres who if left alone would probably go to their own doctor. When I put this complaint to Health Visitors they invariably replied that they only urged people to go to the centres who would they felt sure go nowhere. But one knows the tendency of the keen person to magnify his or her job and there is little doubt that there is such a tendency. The Medical Officers of Health in the areas always said that such action was against their instructions and complaints were always enquired into and a reproof if necessary administered. But the fact remains that in nearly every area the doctors complain about their patients being as they say "canvassed to go to the centres."

THE METHODS OF DOING MEDICAL INSPECTION AND GIVING ADVICE AND MEDICAL TREATMENT AT CENTRES.

30. I now come to consider the methods by which this work is being carried on, and here I find much more difficulty in coming to definite conclusions. The Committee will see from the analysis of the replies received from the Medical Officers of Health of the country how greatly the practice varies as regards the employment of whole or part-time practitioners and how greatly Medical Officers of Health themselves differ in their views.

31. Of two county areas visited one employs in its Tuberculosis, Maternity and Child Welfare, and Venereal Diseases Services 31 whole-time officers and 7 part-time officers, of whom 3 are doing the Maternity and Child Welfare work and 3 are specialists doing eye and venereal diseases work respectively.

32. In the other county the medical inspection of school children and the tuberculosis work are done by whole-time officers. All the other centre work and treatment are done by private practitioners, either general or specialist.

33. Of two urban areas, similar in many respects, in one the minor ailments are done by local general practitioners, the specialist treatment by local specialists, but the Maternity and Child Welfare work is done by a whole-time officer. In the other area all the centre work is done by whole-time officers, etc., the specialist work alone being done by part-time specialists.

34. I need not go into the circumstances of each area, but it may be said that the general tendency is to employ whole-time officers for school inspection; also for the treatment of the really minor ailments of school children, for Maternity and Child Welfare work (with a marked preponderance of women officers), and for ante-natal work (again with preponderance of women) and to employ local specialists on a part-time basis for the treatment of eyes, nose, throat and ears, ringworm, venereal disease, and orthopædic cases, though even this latter branch is occasionally carried out by whole-time officers. According to Sir George Newman *medical inspection* is in fact a whole-time service with few exceptions, these being in the Counties of Buckingham, Derby, Hertford and Oxford. This was not always so. In the early days medical inspection was frequently done by local practitioners, but it was dropped in most areas for administrative reasons.

35. I cannot do better than quote on the general question the words of a County Medical Officer in an area largely urban to whom I wrote after reading his answer to the questionnaire asking him to expand something he had said there :—

"I am entirely in favour of whole-time officers except for specialist services. The choice is better than if restricted to the local practitioners.

Difficulties in using part-time Officers.

(a) Difficulty of getting into touch with officers engaged in public work for a few hours only each week.

(b) Lack of supervision and control of health visitors by doctors whom the visitors see only a short time weekly.

(c) Difficulty of getting part-time officers to keep reliable records, render correct returns, or furnish reports on special cases or questions without undue delay.

(d) Great difficulty in getting part-timers to appreciate the limitations of the work which properly can be carried out at a welfare clinic.

Ethical.

Difficult for a part-timer to express an honest opinion and to afford suitable advice on the case of women and infants known by him to be the private patient of a competing practitioner."

36. Two striking letters on this subject came from two County Medical Officers in response to my request for a personal experience. I précis the contents :—

(a) — where considerable amount of school medical inspection is done by local practitioners. Has no doubt it would be better done by whole-timers, because control of staff cannot be so efficient—in case of illness of officer impossible to move part-timer from one area to another; part-timer naturally regards private practice as having first call on his time—the income from public work usually very small proportion of total income; awkward to send part-time inspector to home when special inspections and reports have occasionally to be made, *e.g.*, mental deficiency; difficulty in keeping appointments, or taking part in investigations into outbreaks of infectious diseases in schools as sometimes school medical officers should do; part-timer begrudges time spent on reports; finally, from experience of both kinds of officer, has no hesitation in saying that best work in medical inspection is done by whole-time staff.

(b) — all inspection work done by local practitioners and most, if not all, the Maternity and Child Welfare work. County Medical Officer believes in enlisting the interest of the private practitioner in the work, particularly when he happens also to be a part-time Medical Officer of Health; private doctor employed is brought more closely into touch with preventive medicine and learns to appreciate some of Medical Officer of Health's difficulties; private doctor is working in area where he is well known and can exert great influence in homes. He reports that the work is well and thoroughly done, but agrees that there are some administrative difficulties which he overlooks because of compensations. He concludes with "so long as the various public health services have to be

carried on, the more the general practitioner is enlisted into them, the greater benefit to the community at large."

37. I may as well give here other expressions of opinion by Medical Officers of Health who have had experience of both systems:—

> Practitioners have been known to advise patients not to attend Welfare Centres for fear it might result in the transference as private patients to the centre officer of patients attending the centre.

This is no fanciful objection. In an area where the Maternity and Child Welfare Centres are manned partly by whole-time and partly by part-time officers, the attendances at the centres officered by the former were undoubtedly superior to those at the latter and in the course of my interviews with the local profession in various areas this fear of losing patients to a competitor was voiced several times. In large urban areas where the number of possible part-time officers is large and where some of the doctors would never get a chance, or only at a very remote period, this is a real difficulty. But in an urban area of moderate size, where the duration of service is one or two years and the practitioners must necessarily have a longish interval between periods of service, I was assured that this element of jealousy was scarcely apparent, and in a county area where all the centre work is done by the local practitioners who have periods of six months' service in rotation, this difficulty does not arise. But in the areas served by each centre in this area there are generally only 2 or 3 practitioners, so that the rotation is easy.

38. Another Medical Officer of Health, with a predisposition in favour of using part-time officers, and who uses both kinds, told me that the detail work, records, and keeping in touch with the general scheme was undoubtedly done better by the whole-time officers.

39. A common objection to the part-time system was voiced by a Medical Officer of Health, who wrote:—

> "There is a real difficulty in keeping up any sort of uniformity of procedure and standard when officers are often changing. The new officer will frequently have entirely different ideas as to feeding of children, etc., and will show it in a manner exceedingly confusing to patients and to nurses. It is also more difficult to standardise the methods of granting free or cost-price milk foods, etc. (a very important matter in an area like mine) when one is using local practitioners. There is a subtle temptation for them to be more generous than is necessary."

40. Another significant statement by a very judicious Medical Officer of Health sums up an opinion very generally held:—

> "If private practitioners were all more or less reasonable individuals and remembered that when they are doing the clinic work they are *public servants*, and if they tried to forget distinctions between their own patients and somebody else's, their inclusion in the local authority's medical scheme might have very distinct advantages. On the other hand the use of whole-time assistants permits of standardisation of methods and does away with many administrative difficulties."

41. More than one correspondent doubts very seriously whether the private practitioner really wants the work—is really interested in work which is largely of a preventive nature and so different from his daily work which is mainly concerned with dealing with really sick people or people who think they are sick, while the work of the centres is very largely concerned with dealing with people who are well and want to be kept well, or with people who have got to be sought out and induced to get treatment for defects which they hardly recognise as such.

42. In a rural county where private practitioners are used for Maternity and Child Welfare work, the Medical Officer of Health says the clinical work as a whole is good, but it is rare to find the combination of a good clinician with one who is really interested in the preventive side, and all that is entailed, in the way of records, reports, and following up.

43. But I have met and heard from several Medical Officers of Health who are convinced believers in the advantages of using the part-time practitioner with all his administrative disadvantages. One of these whose scheme seemed to me to be very successful confessed that in the early stages of his official career he was much more impressed with the disadvantage on the administrative side than with the advantages of using the private doctor, and he launched his scheme in which the private practitioner is used as fully as possible with considerable qualms. After several years of experience he is convinced of the superiority of his plan for several reasons:—

> (1) The relations between the Medical Officer of Health and his whole-time assistants and the profession generally have improved out of all knowledge. (Of the good relations which now exist I have had ample evidence);
>
> (2) the private practitioners who have taken part in the scheme (now the majority of those in the county) are taking a real interest in preventive medicine. (Of this also I had evidence gained in watching the work done at the centres and talking with the doctors who were doing it.)

44. Another County Medical Officer of Health is of opinion that the employment of private practitioners (if they were willing and keen to do the work) would be more economical than his present scheme of employing whole-time officers, because there would be much less travelling to be done, which is an important item in such areas as his.

45. Another Medical Officer of Health draws attention to the danger of the use of whole-time specialists. He particularly singles out the Tuberculosis Officer who, he says, tends to be young, with little general experience of differential diagnosis of chest diseases because of want of access to clinical material under hospital conditions. He goes on, however, to point out the administrative advantages of the whole-time officer—the ease with which he soon comes to handle the admission of cases to the appropriate institutions, the filling up of forms (a very necessary matter in a big scheme), the following up of contacts, etc. This kind of work would, he thinks, not appeal to the private specialist and yet it is difficult to divorce it from the ordinary work.

CONCLUSIONS.

46. As usual, there is a good deal to be said on both sides. The administrative advantages of the whole-time officer must be conceded—the question is do these admitted administrative advantages outweigh the advantages claimed by those who have tried both methods and come down on the side of the part-time doctor for clinic and centre work of various kinds? I think they do not, *given the cordial co-operation of the local profession*. It seems to me that it would pay any local authority and its Chief Medical Officer handsomely to reduce their whole-time staff to the minimum necessary to supervise the scheme in general and do the necessary office and administrative work using the local practitioners for all centre and treatment work, if by doing this they could ensure the advantages claimed, and I think fairly claimed, by those who are firm believers, after experience, in the employment of local practitioners. These advantages may be summarised as:—

> (1) harmony in the ranks of the whole local profession and the creation of a feeling of solidarity among all ranks as part of the health service of the area;
>
> (2) the enlisting of the private practitioner (general and special) in the practice of preventive medicine—no small gain;
>
> (3) the security that the clinical work of the area was being done by practitioners whose general interest and training made them more expert in that branch of the service than could be expected from practitioners whose training, leanings and ambitions lie mainly in the direction of the administrative branch of the service;
>
> (4) the knowledge that the experience gained by the private practitioners in their private practices was being placed at the disposal of those persons for whom the local authority is responsible; and
>
> (5) the certainty that the scheme was inevitably making those taking part in it more generally efficient practitioners in both the preventive and curative branches of their profession, thereby raising the standard of the whole local profession.

47. Such a scheme with such advantages would I feel sure greatly appeal to every progressive public health authority if put persuasively. It would also receive the cordial support of many Medical Officers of Health if they could be convinced that such a scheme was feasible and that it had the real backing of the local profession, and they would *have* to be so convinced before they could be expected to advocate such a scheme to their local authorities.

48. The difficulties must not be minimised, and before attempting to get local authorities to modify existing schemes so as to favour for future vacancies or developments the employment for clinical work of local practitioners in preference to whole-time officers, a great deal of educational work is necessary *among the members of the profession*.

49. It seems to me that the majority of the profession need first of all to be told, or better still, *shown* what is going on at these medical inspections and centres. No obstacle would be placed in their way by Medical Officers of Health, many of whom have bewailed the fact to me that in spite of open invitations it is the rarest thing to get a local practitioner as a visitor to one of the centres. I suggest that active Divisions cannot do better work than by organising in collaboration with the Medical Officer of Health, visits of their members, a few at a time, to the local clinics.

50. There I think they would find that some of their ideas about the encroachments on their field of work are wrong or exaggerated. They would find that the work done is highly necessary and that most of it is work that has never come

their way; and, noting the character of the people who attend, they would I think agree that the vast majority are not people who would have sought (or indeed could afford to seek) the services of any doctor privately; that if the work was not being done at the centres (whether by whole- or part-time practitioners) it would mostly not be done at all, or done at the hospitals.

51. They would find that a genuine attempt is made to induce those who use the public centres to go to their own doctor if they have one. Indeed in many areas the arrangements seem very elaborate and strict.

52. Having arrived at this point they would be in position to consider whether they, as private practitioners *wanted* to do this work, whether they were sufficiently interested in it. And if, as I hope, they did want it, they might begin to ask themselves why it had got (as it so frequently has) into the hands of whole-time officers. Then they might discuss the administrative reasons which have led so many Medical Officers of Health to advocate the whole-time method and they would (assuming a sympathetic Medical Officer of Health) begin to discuss the ways and means of minimising these difficulties, realising that unless they were prepared to meet the Medical Officer of Health half way they could not hope to get this work. The Medical Officer of Health is naturally judged by the public and his local authority by the smoothness with which his scheme works and its ability not only to deal with patients, but to satisfy the local authority and the Ministry of Health by its records, etc., that the work was being done in accordance with plan. They would realise that sacrifices must be made by the individual doctor if he wants to take his part. He must be prepared to be punctual and to put his public appointment first (it can be done; in one area where the work is being done by local practitioners the Medical Officer of Health assured me he had never once been let down in several years). He would have to sink petty jealousies about some of his neighbours being employed before him or even in preference to him.

53. I hope that at this point they would also begin to ask themselves why the present system had been allowed to grow up without apparently any serious attempt ever being made to get the local authority to try the system of employment of local practitioners. And they would discover in many areas that in spite of the urgent and repeated entreaties made by the Association in the early days of school inspection and treatment that each Division should approach its local authority with a scheme and do its best to promote the acceptance of such a scheme—they would discover that no such serious attempt ever had been made; that the position had been allowed to go by default and that the activities of the Division had been confined to grumbling about the *fait accompli*.

54. Looking back over the history of this movement I cannot help feeling that the profession in general has failed to take the long view; that we have not realised that the attitude of the public towards health questions has gradually but very decidedly changed, and that we have hardly changed our attitude. The theory of the family doctor as the practitioner who is deliberately chosen by the head of the family to be the guardian of the health of the whole family is a beautiful one, but unfortunately it never was more than partially applied. The economic circumstances of the vast majority of the people in this country are such that (except under contract systems) they simply cannot afford to go to a doctor except when they are really ill. The private doctor never gets a chance of really watching over the family health—they come to him when the mischief is done. It is not his fault, it is not the fault of the patient. The reason is stern economic necessity. If the family doctor theory could have worked properly there would have been no need for treatment of defective school children. Their defects would have been found out and treated at their inception by the family doctor. But 50 per cent. or thereabouts of them turned up and continue to turn up at the medical inspections with some physical defect or other and the public naturally demanded that they should be attended to. *We* demanded it. And now the public are being educated to try to keep their children clean and healthy and the means of doing this are being offered to them, not by the family doctor—he has never been organised or paid for any such work, as he might very well be—but by the health and school authorities.

55. The fact is the private practitioner has not been fitted into the new scheme of things, except partially in the National Health Insurance system. By this means the private practitioner has been employed to look after the health of the workers, who have been provided with a real family doctor. His *duty* is to treat them when ill and his *interest* is to keep them well. I suggest the Association should concentrate its attention on methods of fitting the private practitioner into the social scheme so far as the preservation of the health of the unborn child, the expectant mother, the infant and the school child is concerned, seeing that the State has made itself responsible for these, though by no means as completely as for the workers. We have our plan for the inclusion of a considerable section of the dependents in the National Health Insurance scheme, but while we wait for that the State is handling a considerable part of their medical interests in another way. I submit that we would be doing a great service to the profession if we educated them to claim and to take their part in the present scheme, instead of bemoaning the encroachments on private practice. The Association would be on much stronger ground if it took seriously in hand the education of the profession and of the public to a belief in a better way of doing the work which is being done by the public authorities because nobody was doing it before they took it in hand.

56. It is true that much time has been lost and the whole-time method seems definitely to hold the field in a large number of areas. But on the other hand there are areas in which the Medical Officers of Health are warm and practical supporters of the employment of the local practitioners. In the majority of areas the part-time specialist is employed; there are other areas where the Medical Officer of Health is quite capable of being converted (and in turn of converting his local authority) as to the superiority of the part-time clinical officer if he were sure the local profession meant business and would meet his administrative requirements as far as possible. Not half enough trouble has been taken in most areas either by the general practitioners or the Medical Officer of Health to prove to each other that they are men and brothers, and each interested in the other man's side of the question. The areas I visited in which the relations were really cordial were a source of great pleasure to me and I could not help feeling that the public and the local authorities of those areas were to be congratulated. There is no reason why there should not be many more such areas, given a desire on both sides to understand the other man's difficulties.

57. It would be ungracious were I to end without a warm tribute to the kindness of the Medical Officers of the areas I visited. They took a great deal of personal trouble to give me all the help and information I required and in private conversations helped me a great deal to clear my ideas. And it is only right to mention that many Medical Officers of Health, in replying to the questionnaire of the Committee, gave very copious additional information and were always ready to reply to the letters I wrote to many of them soliciting their personal as well as their official views.

SUB-APPENDIX.

CASES ATTENDING MINOR AILMENTS AND CHILD WELFARE CENTRES IN ENGLAND.

I.—MATERNITY AND CHILD WELFARE CENTRE (COUNTY INDUSTRIAL AREA).

	Remarks.
1. Old case. Age 4 yrs. 7 mos. Wt. 30¾ lbs. First attended at age of 4 yrs. 2 mos. Suffering from debility, following measles.	Poor condition, suffering from anæmia. Carious teeth. Blepharitis. Bad mothering. Referred to dentist.
2. Old case. First attended at age of 3mos. Was underweight and under-fed.	Age 1 yr. 2 mos. Wt. 19 lbs. 10 ozs. Healthy, attends for weighing and examination at regular intervals.
3. Old case. Age 4 yrs. 4 mos. Wt. 30 lbs. First attended at age of 1 mth. Breast fed, premature infant.	Attends regularly for weighing and exam. Suffering from ulcerated mouth, enlarged congested tonsils. ? whooping cough, under own doctor.
4. New case. Breast fed, occasional feed of Nestlé's milk.	Tendency to rickets. Mother comes for advice as her milk is failing.
5. Old case. Age 2 yrs. 3 mos. Wt. 25 lbs. First attended at age of 1 yr. 5 mos. Wt. 19 lbs. Under-fed.	Healthy, attends irregularly for weighing and exam.
6. Old case. Age 4 yrs. 5 mos. Wt. 36¾ lbs. First attended at age of 4 yrs. for slight strabismus.	Anæmic, but improving, wearing spectacles.
7. New case. Age 2 yrs. 6 mos. Wt. 23 lbs. 14½ ozs. Mother worried, because child is small.	Under-weight. Slightly rickety, otherwise healthy.
8. Old case. Age 3¼ yrs. Wt. 29 lbs. First attended at 7 wks. Did not attend again for 18 mos., then very rickety.	Under-weight. Rickety (improving). Carious teeth, referred to dentist.
9. New case. Age 2¼ mos. Wt. 10 lbs. Attended for advice *re* feeding.	Healthy.

	Remarks.
10. Old case. 3rd pregnancy. Midwife's case.	5 mos. preg., complaining of vomiting, fainting. Has a hæmic murmur. Slight albuminuria and is constipated.
11. Old case. ? pregnancy.	No signs of pregnancy. Complaining of menorrhœa, feeling fœtal movements. Age 45. Last pregnancy 1906.
12. New case. 3rd pregnancy. Doctor's case. Ref. to C.W.C. by H.V. because mother uncertain of length of pregnancy. Has child 14 mos.	7½ mos. preg. Healthy. Normal pregnancy.
13. Nursing mother.	Complaining of pain in hip and leg. ? rheumatic. Ref. to own doctor.
14. Old case. 1st pregnancy. Midwife's case. Advised to come by sister who attends Welfare Centre.	5 mos. preg. Complaining of constipation. Found to be healthy, given advice *re* diet, etc.
15. New case. 6th pregnancy. Brought by midwife.	4½ mos. preg. Complaining of sleeplessness, loss of appetite, depression. Albuminuria found.
16. New case. 5th pregnancy. Midwife's case.	6 mos. preg. Has varicose veins, otherwise healthy.
17. New case, sent by midwife.	Found to be anæmic, ref. to own doctor for treatment.
18. New case. 1st pregnancy. Doctor's case.	6 mos. preg. Found to have slight degree of pelvic contraction, and varicose veins, otherwise healthy.
19. Old case. ? pregnancy. Came of own accord.	No preg. Complaining of sterility. Healthy.
20. Old case. 2nd pregnancy. Ref. by neighbour.	3½ mos. preg. Complaining of pain in abdomen and dizzy feelings. Found to be constipated, otherwise healthy.

II.—Minor Ailments Centre (Town Area).

List of First 20 New Cases Attending Minor Ailment Clinic.

Condition found.	*What was recommended or done.*
1. Temp. 98.6. Has had sore throat for one week. No vomiting, feels well. White patch above left tonsil, slight congestion of fauces.	Swab taken. Notified diphtheria. Removal to hospital arranged.
2. Wt. 2 st. 7 lbs. Listless and tired, poor appetite, delicate looking boy.	Radio Malt. To return in 2 weeks.
3. Temp. 99.4. Rash on back, chest and abdomen. Legs and arms free. No irritation, feels well, throat clear. Patch of dermatitis on back of neck.	Excluded from school. To see Dermatologist. ? ringworm. Mist. alba. b.d.
4. Wt. 2 st. 13 lbs. 8 ozs. Going to sanatorium under observation. ? T.B. Had pneumonia before Xmas. In hospital 6 weeks. Sent by private practitioner *re* teeth.	Cod liver oil and malt ordered. To see dentist.
5. Bruised hand.	Paint with iodine.
6. Styes and low degree of conjunctivitis in both eyes. Vision = 6/6.	Lotion given
7. Temp. 100. Tonsils congested. No body rash. Lachrymation. Influenzal cold.	Medical notice given (*i.e.*, to see private doctor). Throat swab taken, excluded from school. To return in 4 days if private doctor not called in.
8. Mother states child frequently wants to pass urine, but is unable to pass very much.	Urine *nil* abnormal. Mother advised to seek for thread worms. To return in 1 week.
9. Corneal ulcer.	Lotion and ointment given. To return in 1 week.
10. Abscess right little finger.	Foment. To attend daily.
11. Both eyes 6/6 without glasses. Lachrymation left eye since infancy. ? obstruction lachrymal duct.	Medical notice given.
12. Scaly sore on back of neck.	Ointment given. To return in 2 weeks.
13. Had Diphtheria Feb., 1928.	Throat swab reported negative by private doctor. To return to school.
14. Blepharitis left eye.	Ointment given. To return in 1 week.
15. Septic finger. Impetigo of face.	To attend daily for treatment.
16. Laceration of head.	Two stitches inserted. To attend daily for treatment.
17. Influenzal cold. Temp. 99. Tonsils congested.	Medical notice given. Virol ordered.
18. Stye on right eye, offensive breath. Teeth decayed. Tongue furred. Throat clear. Vision—6/6 partly.	Bathe crusts off eye, ointment given. To see dentist. Retinoscopy arranged.
19. Septic finger. Pus under bed of nail.	To consider removal of entire nail. Foment. To attend daily.
20. Sub-cuticular whitlow. Night starts and insomnia, wt. 3 st. 10 lbs.	To attend daily for treatment. Auto-suggestion.

III.—Ante-Natal Centre (Town Area).

Expectant Mothers.

Reason for attendance.	*Defects found.*	*Action taken.*
1. Sent by midwife for examination.	Bad varicose veins. Otherwise normal.	Note sent to midwife. Advice *re* veins.
2. Sent by midwife. Primipara.	None.	Note sent to midwife.
3. Primipara. Brought by mother	Pelvic presentation.	Has engaged with private doctor. No action taken.
4. Sent by midwife. Primipara.	Pelvis slightly contracted.	Note sent to midwife.
5. Wishes to go to hospital for confinement.	General health poor.	To attend dinners. To apply to hospital herself.
6. Sent by midwife. ? 6 months pregnant.	Not pregnant.	Note sent to midwife.
7. Sent by midwife with hæmorrhage.	Has only one kidney. High vertex. ? Placenta prævia.	Note sent to midwife to have absolute rest for a week and to be visited from Centre. Refuses to go away for a rest.
8. Sent by midwife for examination. Sickness.	Flabby abdominal muscles. But no other abnormality.	Advice *re* food, rest, etc. Note sent to midwife.
9. To know if pregnant.	Contracted pelvis.	Told she was 2½ months pregnant. To attend dinners.
10. Advice *re* pregnancy.	Twins. Slightly contracted pelvis. Has had Cæsarian previously.	Previously advised hospital. Told to pay 5s. for doctor as she refuses to go away for confinement. (This refers to midwifery insurance scheme.)
11. Advised by midwife to go to Maternity Hospital. Has attended at M.C.W. Centre.	Very contracted pelvis. General health very poor.	Sent to Maternity Hospital.
12. Sent by midwife. Primipara.	Normal.	Advice *re* foods, etc.
13. Sent by midwife.	Normal. Teeth bad.	— —
14. To know if pregnant. Has attended Centre with other pregnancies.	2½ months pregnant. Nil abnormal.	Advice *re* foods, etc.
15. *Re* pregnancy. General advice.	3½ months pregnant. Nil abnormal.	Advice *re* foods, etc.

Reason for attendance.	*Defects found.*	*Action taken.*
16. To know if pregnant.	Normal. Some pyorrhœa.	Advice *re* teeth, 2 months pregnant.
17. Sent by midwife *re* prolapse and pregnancy.	Prolapse and contracted pelvis.	Advised to pay 5s. for doctor. Note sent to midwife. (Refers to insurance scheme.)
18. Pains in abdomen.	Found to be in labour.	Sent to hospital.
19. Sent by midwife for examination.		
20. Bad teeth. Pregnancy.	Bad teeth. Otherwise normal.	Given note for dentist.

APPENDIX (B).

REPORT BY MEDICAL SECRETARY ON INVESTIGATION INTO THE OPERATION OF MATERNITY AND CHILD WELFARE CENTRES AND SCHOOL CLINICS IN CERTAIN AREAS IN SCOTLAND.

1. In accordance with the instructions of the Private Practice Committee I made enquiries from the Scottish Medical Secretary as to which areas in Scotland would best repay examination on the lines of the enquiry carried out by me in England. As Dr. Drever was of opinion that Aberdeen and Glasgow should be visited. I communicated with the respective Divisions and Medical Officers of Health and School Medical Officers and visited the former city on November 5th and 6th and Glasgow on the 8th and 9th. At both places I followed exactly the same procedure as I had adopted in the earlier enquiry in England, first procuring from the Medical Officer of Health a complete statement as to the health activities of the city, then having a general talk with him so as to elicit certain points of local importance, visiting the centres I had chosen as samples, and finally meeting the Division or Branch. As in Scotland the school medical service is separate from the Public Health Department I also consulted with the School Medical Officer of each area.

ABERDEEN.

2. The situation in Aberdeen is extraordinarily interesting, because there the Town Council has adopted the plan submitted by the Medical Officer of Health in 1924 of taking over the Poor Law Hospital, of transforming it into a Municipal Hospital, and of linking up that hospital with the various public health services of the city. The entire *institutional* care of the sick poor is now in the hands of the Corporation, but the domiciliary work is still done by District Medical Officers in the employment of the Parish Council. It is beyond the scope of this report to enter into the many complicated questions which are agitating the public and the medical profession in Aberdeen in connection with this transformation. Some of the questions have such a strong local personal and corporate bearing that it would be presumptuous for any outsider to express opinions. But it is useful to bear in mind that Aberdeen is faced with one difficulty which did not occur when Bradford municipality took over its Poor Law Hospital and can only arise in a few instances. The situation in Aberdeen is complicated by the existence of a university and a teaching medical school, and judgng from the Aberdeen experience it is not easy to reconcile the differences of opinion which may easily arise, and have indeed arisen, between the Corporation on the one hand and the university and the medical school on the other.

3. In Aberdeen, as in Scotland generally, the Education Service is under the control of an elected *ad hoc* Education Committee, and in Aberdeen, as in Glasgow, there is a separate School Medical Officer who has no organic relation with the Medical Officer of Health. The medical inspection in Aberdeen is carried out by the Chief Medical Officer and by a whole-time Assistant Medical Officer; the treatment of the usual minor ailments is carried out by the whole-time officers; and part-time specialists do the eye, and nose, throat and ear work. The dental work is done by two whole-time dentists, and there is a clinic for tonsils and adenoids in the hands of a part-time specialist. The children who need orthopædic treatment which can be given by physical instructors are so dealt with; where operative treatment is necessary, the children are referred either to the Royal Infirmary or to the Municipal Hospital.

4. I visited one of the school clinics, and, though only dental work was going on, I made enquiries into the system of inspection and treatment and found it much the same as in the English centres I had visited. The number of children found defective on entrance seems very low—out of 2,533 five-year-old pupils examined in 1927, only 18 per cent. were notified to parents as suffering from physical defects, which were of the usual nature. One thing, however, impressed me as a real difference in the procedure as compared with all the areas previously seen, and that is that a much stricter line seems to be taken by the Education Authority in trying to get the parents to provide the attendance necessary, elsewhere than at the clinics. The form of certificate sent to the parent on the discovery of any defect specially draws the attention of the parent to the fact that it is his duty to provide any treatment that is necessary, and from all I could gather the number of children who get attention either from the private doctor or from the hospitals is greater in Aberdeen than it is in any English town known to me. The School Medical Officer assured me that if pressure is put on the parents and they are given to understand that it is *their* responsibility to get the child's physical defects attended to, the great majority will do it. I was not able to satisfy myself whether this does not mean that a much larger proportion of the defective children in Aberdeen get their treatment at the hospitals. The School Medical Officer in his last Annual Report says that the clinic for minor ailments is intended "to ensure that children absent from school for minor ailments are having the instructions given by the family doctor or by the staffs of the various hospitals carried out."

5. The Medical Officer of Health for the County of Aberdeen who kindly assisted at my interview with the Medical Officer of Health and the School Medical Officer of Aberdeen City told me that they were very successful in the County in getting parents to deal with these minor defects; that if it was found at school that the defective children were not being attended to, a nurse followed the case up and if necessary an official threat of prosecution was sent to the parents, which generally proved effective. One got the impression that in the County, as in the City, insistence on parental responsibility is a rather more real thing than in corresponding areas south of the Border. But, as I said before, this may merely mean that the children, instead of being treated at the clinics, are being treated at the hospitals.

Maternity and Child Welfare Work.

6. There are 8 Child Welfare Centres in the City, 2 of which are run by a voluntary organisation. The others are served by a whole-time officer who was for many years a general practitioner, got interested in this kind of work and has for the past few years been devoting his whole time to it. I visited one of the centres and saw him at work, giving a lecture on feeding troubles to a large number of mothers. He told me that his previous experience in general practice had been of inestimable value to him in his present work and, judging from the practical nature of his talk to the mothers, I could well believe it.

7. The Health Visitors call on all mothers residing in habitations of three rooms or less, unless they have been attended in their confinement by a doctor who indicates that he does not want the Health Visitor to call. The mothers go to an Educational Centre where mothers and babies who seem unhealthy are picked out and recommended to go to a clinic where detailed examination and advice are given, but little or no treatment. I got the same impression here as in every other centre I have visited, namely, that the great majority of those present would be very unlikely to seek advice for which they had to pay.

8. There are Ante-Natal Clinics at the Maternity and City Hospitals, both served by members of the Honorary Staff. All midwives are advised to send every primipara to one or other of the clinics, or, if the patient will not go, to send her urine for examination. Other cases may go if they like. Suitable cases are taken into the Maternity Hospital.

9. There is an excellent institution for mothers and babies at Burnside House where there are 42 cots for weakly babies sent from the Maternity Hospital. They are mainly babies of mothers who are ill and cannot nurse them, or premature births. Mothers are occasionally sent for test feeds, etc.

10. I visited the City Fever Hospital, with its Tuberculosis Department for in- and out-patients, and beds for pneumonia and marasmic infants; also the Woodend Hospital—lately Poor Law. This is a large hospital which was built some 25 years ago. The effect of the Insurance Act, I was told, greatly lessened the number of pauper in-patients. The Army took it over and in 1918 returned it, after which it stood empty till a little over a year ago. The cases are now of a general nature, and I was informed that they mainly consist of people who had been on the waiting list of the Royal Infirmary and who had been recommended for admission by the family doctor or by the district poor law doctors.

11. I had a very interesting discussion of the general and local position with a large meeting of the Aberdeen Division. I found that members are taking a very acute interest in the questions raised in the Private Practice Interim Report, but still more in the local hospital question, on which feeling runs high. There seemed to me to be a strong body of opinion among the general practitioners that they have more to fear from the encroachments of the hospitals than from those of public health and school centres. Many of the younger men seem keen to be used in the communal clinical work, if they could get an opportunity, and I found what I should have least expected to find in Aberdeen with its record of strong individualism. There was a section—and not a very small one—which was evidently quite prepared for and indeed in favour of a whole-time medical service for domiciliary and other purposes.

12. The Medical Officer of Health (Dr. J. Parlane Kinlock), who has been appointed Chief Medical Officer to the Scottish Department of Health, Edinburgh, made this significant statement in the preface to his Annual Report for 1927:—

> "Faced with the reform of the whole of our local health administration it is for the local authority, the medical profession, and the public generally, to determine whether the time is not overdue when the general medical practitioner should be re-established in his position of full responsibility as family doctor, responsible for watching over the family health, responsible for the prevention of disease, and utilising for that purpose the whole of the official machinery that the local authority has provided. I am convinced that it can be done, and that just as there must be a complete interlocking and interchanging of the work of the statutory health authority and the voluntary agencies, so the co-ordination of the work of the statutory health officer and the private medical practitioner within a complete medical organisation will provide the adequate medical service that is the desire of everyone interested in social welfare."

This is a significant statement coming from a man who will shortly be in a position which will enable him to influence very considerably the Scottish Secretary and through him the Scottish local authorities.

GLASGOW.

13. The Glasgow Corporation employs in its Public Health Department 22 whole-time and 31 part-time practitioners—19 of the latter are employed in V.D. work, the remainder being chiefly specialists. There is one voluntary Ante-Natal Clinic run by 4 part-time women officers, at which all the cases come from midwives.

14. I visited 1 V.D. Clinic at one of the general hospitals, and 2 *ad hoc* Clinics; 3 Maternity and Child Welfare Centres; a creche for day children; an institution used for Ophthalmia Neonatorum cases, for the giving of light treatment, and for cases of congenital syphilis; and the Stobhill Poor Law Hospital, with 2,000 beds and an average of 1,700 occupied beds, where every case is sent in by a doctor, either the poor law doctor or a private doctor. This is an excellent example of what is going on in the modern Poor Law Hospital. Four years ago there was 1 Superintendent and 4 residents; no visiting staff. To-day there are 13 visiting consultants, all paid, and 15 residents, and the hospital is used by the University for teaching purposes.

15. In the Educational Medical Department there is a P.M.O., a deputy, 12 whole-time assistants, 4 whole-time dentists, and the following part-time officers: 2 aurists, 4 oculists, 3 dentists, 1 mental specialist.

16. I saw a medical inspection of school children, where boys of 9 were being examined. Very few of them seemed to be quite normal and healthy—the usual defects of eyes and teeth, tonsils and adenoids, minor skin diseases and cough.

17. I afterwards saw a School Clinic at work and was impressed by the great pains taken to prevent those who might fairly be expected to provide treatment themselves from getting it at the public expense. The form issued to the parents stating that their child will be inspected gives the parent the option of having his child examined by the family doctor, but this is rarely if ever taken advantage of. The form telling the parent that some defect has been discovered says "Those who are able to obtain the necessary treatment from their own doctor should do so" and contains the following declaration which has to be signed: "I wish to have the child . . . treated by the School Doctor. I am unable otherwise to obtain the necessary treatment." The personal enquiries made seemed to me to be very strict. Three mothers were answering questions as to financial circumstances while I was present:—

(1) Husband unemployed; parish relief; 6 in family; total weekly income 31s. 0d. Treatment granted.

(2) Labourer's wife; family income £3. 17s. 0d., from father and one boy over 14 working; 7 children under 14. Treatment granted.

(3) Family income for total of 5, £4. 0s. 6d. Refused treatment and told to take boy (tonsils and adenoids) to family doctor. She said she would take the child to the hospital, where no enquiries would be made.

18. I then visited in succession (1) special school for physically defective children (congenital hearts, rickets, incipient tuberculosis, general debility); (2) a school for high myopes and an orthopaedic clinic where physical exercises were given.

19. Finally I spent a very interesting hour or so at the City Laboratory under the direction of Dr. R. M. Buchanan (Bacteriologist to the Corporation of Glasgow and incidentally President of the Branch), an institution apparently greatly used and appreciated by the practitioners of the City owing to the anxiety of the Director and of the City Corporation to be of every possible assistance to practitioners.

20. It is unnecessary for me to go into details of what I saw at the various centres, for the story would be mainly a repetition of parts of my previous report. But here, as in Aberdeen, I felt convinced that more care than usual is taken to exclude from the benefits of the various centres people who might possibly provide their own attendance, and here again I could not help feeling that the probable result of this greater care was to direct most of the patients, not to the private practitioner, but to the general hospitals. For at the meeting of local practitioners held at the conclusion of my round of visits, and which was attended by a very representative body of practitioners of all kinds, I found that there was comparatively little complaint of the encroachment of the municipal and educational authorities, but a good deal was said of the activities of the hospitals, which were accused of taking practically anybody and asking no questions.

21. My visits in Scotland, following on those in England, make me doubtful whether there is any real anxiety on the part of any considerable section of general practitioners to take an active part in the local communal medical work—or at any rate to take much trouble to try to induce the local authorities to put the work into their hands. I am strongly inclined to believe that in most areas the majority of the practitioners would be satisfied if they could be convinced that there was no organised pressure by Health Visitors and others to induce mothers to go to and to take their babies to Maternity and Child Welfare and particularly to Ante-Natal Centres. I am not at all convinced that the most stringent efforts on the part of local authorities to confine the work of the centres to the really poor would have the effect desired by many doctors, namely, that of inducing many of the persons concerned to employ a private practitioner. I am inclined to think that the total result of such stringency would be to send a few to private practitioners and many to the hospitals, and that still more would do—nothing.

22. I must end this report as I ended the last by an expression of gratitude to the Medical Officers and School Medical Officers of Aberdeen and Glasgow for the great kindness shown to me by themselves and the members of their staffs, and for the trouble they all took to show me everything I wanted to see and to answer all the questions I put to them. There was in no instance any attempt to force my hand or prejudice my judgment.

APPENDIX (C).

REPORT OF CONFERENCE, HELD 1922-23, OF REPRESENTATIVES OF THE BRITISH MEDICAL ASSOCIATION AND OF THE SOCIETY OF MEDICAL OFFICERS OF HEALTH, ON THE POLICY OF THE ASSOCIATION AND THE SOCIETY AS TO PUBLIC HEALTH MEDICAL SERVICES.

(*Approved by Annual Representative Meeting*, 1923—*Minute* 30.)

I. The Conference has reviewed the obligations and powers imposed and conferred upon local authorities by Acts of Parliament in regard to health administration and the relative position of Medical Officers of Health and general practitioners in schemes of health services. These obligations and powers include:

(a) Medical survey or inspection.
(b) Treatment.

II. Local authorities must give effect to their legal obligations. The extent to which they exercise their powers is in the discretion of the local authority subject to the prior approval of the appropriate Central Government Department.

The Conference is of opinion that benefit would be likely to result from a close co-operation of the local medical profession with the local authorities' schemes of medical survey or inspection and treatment.

III. The Conference is in general agreement with the view of the Consultative Council on Medical and Allied Services as stated in that part of paragraph 6 of its interim report, which recited:

> "Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close co-ordination. They must likewise be brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine."

IV. The Conference is therefore prepared to advise local authorities:

(1) That where private general practitioners place their opinions before local authorities on any proposed scheme of medical survey or inspection and treatment, their representations should have due consideration by the local authority in order that it may be ascertained how far it is practicable or desirable to give effect to their view.

(2) That those engaged in general practice must either be prepared to accept responsibility for the treatment of such of their private patients as are discovered by medical survey or otherwise by the local authority to be in need of treatment, or they should agree that treatment be undertaken by the local authority without regarding such medical provision as an encroachment on their practice. To this end persons found to be in need of treatment should, in the first instance, be referred to their private medical practitioner, or if they have no regular medical attendant they should be advised to consult a private medical practitioner.

(3) Private practitioners should assist local authorities by intimating their willingness or otherwise to undertake the treatment of patients discovered in the manner stated to be in need of treatment.

V. That practitioners, and by arrangement medical students, should have access to centres and clinics established by local authorities, in order that they may gain such experience as the centres and clinics afford.

VI. That private medical practitioners should be able to refer to clinics and centres for advice and treatment patients who would thus be most appropriately provided for.

VII. That payments or charges, if any, made in respect of medical treatment should be either voluntary or of such a character as will not deter persons from seeking advice and obtaining early treatment.

VIII. Centres and clinics should be established and administered for the benefit of:—

(a) Those who are unable, for some reason, to obtain treatment from a private doctor, and

(b) Those who, as a result of supervisory medical work undertaken by the local authority, are discovered to be ailing, and for whose ailments treatment would not be sought unless it were provided by the local authority.

But treatment at centres and clinics should be such as can be actually given therein, and should not include any treatment that makes domiciliary attendance advisable or involves a stay of more than forty-eight hours at any clinic where beds are provided.

IX. The Conference is of opinion that in the interests of harmonious working and the acquirement of clinical experience the possibility should always be considered of clinical work done for the Public Health Authority being carried out through the agency of private practitioners where conditions are suitable.

X. For the purpose of a better understanding, the Conference desires to state further:—

(1) That private general practitioners or consultants accepting offices under local authorities must realise that the duties of these offices require to be fulfilled strictly in accordance with the conditions of the appointments and in priority of all other engagements.

(2) That health policy is settled by local health authorities, not only on medical grounds but after due regard has been given to the closely related questions of administration and finance, local conditions, and other relevant considerations.

(3) That the Medical Officer of Health should so far as possible secure the co-operation of the local medical profession in the discharge of his duties.

(4) That the final decision on health policy must always rest with the local and central authorities.

(5) That it is the duty of the Medical Officer of Health to ensure that effect is given to the decisions of those authorities.

APPENDIX XII.

DRAFT MEMORANDUM WITH REFERENCE TO ADMINISTRATIVE SCHEMES UNDER THE LOCAL GOVERNMENT ACT, 1929.

1. THE Local Government Act provides that within six months after its commencement the Council of every County and County Borough shall submit a scheme of the administrative arrangements proposed to be made for discharging functions transferred to it from the Poor Law Guardians. On the submission of an administrative scheme a notice must be published that representations may be made thereon to the Minister within a period of four weeks. Schemes sanctioned by the Minister will become operative on April 1st, 1930. The influence of the medical profession on the character of these schemes may therefore make itself felt at any time before November next; but it is obvious that in each locality such influence can be brought to bear more effectually during the preparation of a scheme than after its completion. Schemes are already being formulated in a number of areas.

2. The functions transferred by the Act from Poor Law Guardians to the Councils of Counties and County Boroughs fall mainly under three heads—(a) public health, (b) education, (c) assistance in the narrower sense of provision of shelter, food or money. In accordance with the British Medical Association's policy of separating public health services from public services of other kinds and of unifying the administration of public health services as far as possible it is to be hoped that every administrative scheme will contain provisions to this end, and that no scheme will be formulated or sanctioned which simply entrusts the administration of these classes of transferred functions *en bloc* to one Committee. There may be a temptation to take this course, which seems superficially the line of least resistance. Such action, however, is likely to be discouraged by the Ministry of Health, in accordance with the intention of the Act.

3. The main transferred public health services will be vaccination, Poor Law Hospitals, medical out-relief, medical services for children of school age, medical services for children under school age and their mothers, medical services for mental deficiency and mental disorders. The Council of each County or County Borough must, under the Act, appoint a Public Assistance Committee, or may arrange for some existing Committee to act as its Public Assistance Committee. Each Council will then have six Committees dealing with public health services—the Public Health Committee, the Education Committee, the Mental Deficiency Committee, the Maternity and Child Welfare Committee, the Asylum Committee, and the Public Assistance Committee. In County areas the County Council will also have to appoint District Guardians Committees and prescribe their functions, some of which may be of a public health or medical character. In some areas the Mental Deficiency Committee is the Asylum Committee, with the addition of two women members, and in some areas both the Maternity and Child Welfare Committee and the Mental Deficiency Committee are treated as Sub-Committees of the Public Health Committee. It will be possible for a Council to appoint its Public Health Committee as its Public Assistance Committee, so that that Committee may combine the functions of both.

4. In accordance with the policy of the British Medical Association it is desirable that the Councils of Counties and County Boroughs should administer the transferred public health functions as far as possible by virtue of the appropriate Acts relating to public health services, rather than through the Poor Law, and it seems likely that in most cases this will be arranged for in the administrative scheme and that such schemes will be unlikely to be sanctioned by the Ministry of Health unless this is done as far as possible, as, indeed, the Act provides. Each scheme therefore should specifically state that the vaccination services will go to the Public Health Committee; that medical attention to children of school age will go to the Education Committee; that medical attention to children under school age and their mothers will go to the Maternity and Child Welfare Committee; that all medical services of transferred hospitals or institutions will go, in the case of County Boroughs, immediately, or, in the case, of Counties, either immediately, or after a short prescribed period (during which, as a temporary measure, they would be under the Public Assistance Committee), to the Public Health Committee. The service for medical out-relief requires special consideration and might remain under the Public Assistance Committee, or go to the Public Health Committee acting upon its behalf.

5. It is desirable that each Committee should be so constituted as to contain members experienced in the work which the Committee has to do, including members representative as far as possible of the medical profession of the area. Provision is made under other Acts for the appointment of co-optative members to Education Committees, to Maternity and Child Welfare Committees, and to Mental Deficiency Committees. The Local

Government Act now permits of such co-option in the case of the Public Health Committee (in Counties the Public Health and Housing Committee) and the Public Assistance Committee, and makes such co-option mandatory in the case of District Guardians Committees appointed by the Council of a County. The Association believes that it is most essential to efficiency that this power of co-option shall be exercised in most cases, that provision for it shall be made in each administrative scheme, and that there should be suitable medical representation among the co-optative members. This is one of the points as to which, in some areas, it will be necessary to bring particular pressure to bear on the Council, and in this connection it may be well to bear in mind that co-option need not be confined to those who have been Poor Law Guardians or to women, and that where the Act prescribes that some women shall be co-opted a medical woman may often be found to be the most suitable person. The Public Health Committee may appoint a Hospitals Sub-Committee to manage hospitals in its area, and it seems essential that upon this Sub-Committee there should sit members, both medical and lay, experienced in hospital management. It will be for each scheme to provide for this.

6. A clause introduced into the Act at a late stage of its consideration by Parliament makes it incumbent upon the Council of every County and County Borough to make such arrangements as they think desirable to consult any body within their area which they consider representative of the governing bodies and of the medical staffs of voluntary hospitals before action is taken with regard to the provision and use of hospital accommodation. If there be in any area a body which may be consulted in pursuance of this duty steps should be taken at once to ensure that the medical staffs are adequately and properly represented thereon, and it should be particularly noted, in areas where this applies, that the medical staffs concerned include all medical practitioners, whether general or specialist, who are engaged in the work of the cottage hospitals of the area and that these also must be an integral part of any body before it can be considered properly "representative of the staffs of local voluntary hospitals." If there be in an area no existing body suitable for consultation, steps should be taken to form one, by action of the Committee of the Branch or Division of the Association. On this point, probably, it will be necessary very shortly to issue further instructions.

7. In the case of County areas it is part of the policy of the Association that the Council of the County should delegate the exercise of certain transferred health functions to the Councils of County districts which are of a suitable size and which comply with the requirements of the Act* and which have already established and efficiently conducted in their areas health services of a similar kind, thus avoiding overlapping or re-duplication of the work. In administrative schemes submitted by County Councils it is necessary that medical practitioners in such district areas should endeavour to secure the embodiment of provisions for such delegation.

8. In the interests of the unification of the administration of health services it is necessary that there should be in the area of each County or County Borough one chief administrative officer who must be the Medical Officer of Health. To have an independent medical officer in each department and as the adviser and executive officer of each separate Committee would be so obviously wasteful that it is not likely to be sanctioned by the Ministry of Health if proposed in any scheme. But the heads of departments, in so far as they carry out any clinical work, must obviously maintain a position of some independence. The provisions in any scheme dealing with this matter will require very careful attention.

9. The position of transferred Poor Law District Medical Officers is one which will require special consideration. Hitherto they have not been under the administrative supervision of any medical officer and any questions as to their work have been dealt with directly by relieving officers and Boards of Guardians or by the Ministry of Health. It is a question whether they should now be responsible to the Public Assistance Committee or to the Public Health Committee of a Council, and in either case their work must come under the administrative supervision of a medical officer, who would naturally be the Medical Officer of Health of the County or County Borough as the case may be.

10. All the resolutions and memorandums embodying the policy of the Association with regard to these matters should be carefully borne in mind in formulating or criticising an administrative scheme. In particular, reference may be made to the Association's memorandum of evidence submitted to the Royal Commission on Local Government, to the Hospital policy of the Association, and to the three resolutions dealing with domiciliary attendance passed by the Representative Body at Cardiff, which are as follows:—

(i) Domiciliary attendance should, in the best interests of the patients, be provided by private practitioners in the area concerned and not by a whole-time medical officer; (ii) the adoption of the above resolution leaves unprejudiced the position of any medical officers at present holding whole-time appointments in which domiciliary attendance is one of the duties; (iii) if there are in the area no practitioners willing to undertake the domiciliary work on suitable terms, paragraph (i) shall not apply.

There is no objection in principle to the combination in one and the same whole-time appointment of the duties of a Medical Officer of Health and of those of a Poor-law Institutional Medical Officer, but the application of this principle in any individual instance must be governed by local circumstances and by the opinion of the Division or Divisions concerned.

There is no objection in principle to the combination in one and the same whole-time appointment of the duties of a Medical Officer of Health or of a Poor-law Institutional Medical Officer and those of a Public Vaccinator, but the application of this principle in any individual instance must be governed by local circumstances and by the opinion of the Division or Divisions concerned.

Attention is also directed to those paragraphs of the Annual Report of the Council which contain some important conclusions and recommendations under the heading of encroachments on the sphere of private practice.

11. Although the matters referred to in this paragraph have no relation to the administrative schemes immediately to be prepared for submission to the Ministry, it is desirable to note that there are three very important surveys which the Act imposes upon the Councils of Counties, as distinguished from those of County Boroughs. One of these, which must be completed by April, 1932, at the latest, is to review the whole area of the county as regards its division into districts and parishes, and to report any changes in this respect which it thinks desirable. A second is to survey the hospital accommodation for the treatment of infectious disease provided within the County, and to submit a scheme for making such provision adequate for every part of the area. A third survey is with a view to formulating arrangements for securing a whole-time Medical Officer of Health, not necessarily at once, for every district of the County. It is clear that, as with regard to administrative schemes, so with regard to these surveys, which may exercise great effect upon health services and administration, the medical profession should exercise its due influence and should at once prepare itself to bring such influence to bear at the appropriate time.

Immediate Action Required.

12. The situation above described calls for immediate action on the part of every Division and/or Branch. The Branch machinery may be the best for dealing with the County Councils, and the Branch Council should consider the matter at an early date so as to ensure that action will be taken, and that there will be no overlapping. During the next six months, while the schemes of the Counties and County Boroughs are in preparation, and as early as possible during that time, the policy of the Association should be brought to the attention of those who will be mainly instrumental in formulating the local schemes. On the medical side obviously the Medical Officer of Health will occupy a position of very considerable influence, and the first duty of the Division Executive (or the Branch Council) is to get into conference with the medical officer concerned, and take his advice as to the best way of influencing his Council and persuading it that the policy of the Association will be in the best interests of the community. He may know that his Authority has already decided to take a line which the Association would approve, so that in his opinion formal representations might be unnecessary or even harmful. He may be of opinion that it would strengthen his hand if the Division or Branch would send a deputation, and he would be able to indicate the right way of asking for such deputation. He may consider that it would be sufficient for practical purposes if a memorandum were sent to the Council expressing the views of the local profession.

13. If it is thought best to arrange for a deputation this should be done with great care. It is essential that the views of the Association should be put up in a persuasive manner by practitioners who not only know the policy of the Association and are convinced of its reasonableness, but who, if possible, have had experience of public life and have personal influence with the local public men. It will therefore be eminently desirable to add such practitioners to the Executive of the Division or to any special Committee appointed for the purpose. Copies of the relevant documents and any other help that can be given from the central office will, of course, be available, and the Council earnestly hopes that there will be no County or County Borough area in the country whose scheme will not receive the immediate

* The requirements to be borne in mind are that the Council of the County district (1) has set up a Maternity and Child Welfare Committee; (2) has a full-time Medical Officer of Health; and (3) is a Part III Education Authority.

and careful attention of the appropriate unit of the Association. As the future development of medical service in this country depends very greatly on precedents that will be made within the next few months it is imperative that the Association should spend its energies in moulding the schemes of medical service *now* into such a shape as will be agreeable to the profession, rather than that it should later spend energy, time and money in a sort of guerilla warfare against schemes so framed as to be unacceptable to the medical profession and not in the best interests of the public.

British Medical Association.

CURRENT NOTES.

Staffs of Hospitals in the Metropolitan Area and the Local Government Act.

THE new Local Government Act introduces new factors of great importance to the medical profession, and not least to members of hospital staffs. The county councils and county borough councils have to take over the Poor Law hospitals, and, thanks mainly to Lord Dawson, a clause was introduced into the bill which imposes on the council of every county and county borough, when making provision for hospital accommodation, the duty of consulting "such committee or other body as they consider to represent both the governing bodies and the medical and surgical staffs of the voluntary hospitals providing services in, or for the benefit of, the county or county borough as to the accommodation to be provided and as to the purposes for which it is to be used." The King Edward's Hospital Fund for London is taking steps to provide such a committee for the area it covers, and the special point of view of the staffs of the teaching hospitals is not likely to be overlooked by the Fund. But the area covered by the Fund (a radius of eleven miles from St. Paul's) includes many non-teaching hospitals and a considerable number of cottage hospitals, and, so far, there is no indication that the Fund has taken any steps to ensure that the point of view of this section shall be represented on any committee set up. The British Medical Association is therefore approaching the King Edward's Fund, pointing out that it is essential that any committee which is to be recognized for the purpose mentioned in the Act should contain duly accredited representatives of the medical and surgical staffs of all kinds of hospitals in the area concerned, and offering the services of the Association for the purpose of getting such representatives. It is probable that it may be necessary to call together representatives of the staffs of all the hospitals in the area at an early date.

Insurance Against Permanent Disability.

The Public Health Committee of the Association has had its attention called to cases of doctors engaged in public health work who have contracted diseases as a result of their public duties, and who have thereby been rendered unfit for further professional work. There appears to be no legal obligation on a public authority to recompense these unfortunate persons, nor are there any means of compelling an authority to recognize its moral obligation towards them. It is therefore of urgent importance that doctors should protect themselves by insuring against the grave risks they run of contracting disease from patients they may have to attend. Doctors so engaged would do well to consult the Medical Insurance Agency concerning the ways and means of obtaining protection by insurance. For many years the Agency has made a careful study of sickness and accident insurance as applied to doctors. In the ordinary way of insurance many contracts are offered which are of little value to doctors. There is one particular form of policy which, in the opinion of the Agency, is well suited to protect the special interests of medical men. It is known as the permanent or non-cancellable sickness and accident contract. The merit of this particular class of policy is that once it has been granted it cannot be varied or cancelled at the will of the company, and so long as the policy conditions are observed the insurance remains in force up to the age agreed upon at entry, thus ensuring protection up to 60 or 65 years of age. For those holding public appointments provision can be made whereby no payment for claims is made during the first three or six months of incapacity, during which time the employing authority would probably pay salary in whole or in part, but after such period the full amount of the insurance is paid continuously throughout disability up to age 60 or 65. The premiums under such a plan are considerably less than those charged for policies where the sick pay commences immediately disability is experienced; and it must especially be noted that the full sum assured is paid continuously *throughout* the disablement, for usually a sickness policy provides for the reduction of the benefit to half after twenty-six weeks of disability have been paid for.

Consideration of this subject emphasizes the importance of every doctor obtaining a permanent or non-cancellable contract whilst he is physically fit, for then he can select the policy most suitable to his needs; whereas, if the application for insurance is postponed until a recurring disease has been contracted it is not possible to obtain such a policy. Insurance is now very much specialized, but it is in sickness and accident insurance more than any other class of insurance that skilled and unbiased advice is necessary, so that the policy best suited to the particular needs of the individual is obtained. The Medical Insurance Agency can be relied upon to give expert advice and to indicate the most economical policy of insurance to meet the special needs of medical practitioners.

Association Notices.

NOTICES OF MOTION BY DIVISIONS FOR THE ANNUAL REPRESENTATIVE MEETING, MANCHESTER, 1929.

Privileges of Inactive Divisions.

By LANCASHIRE AND CHESHIRE BRANCH: That the Annual Representative Meeting instructs the Council to consider the possibility of dealing with inactive Divisions by limiting one or more of their privileges of representation at the Annual Representative Meeting.

Abatement of Unnecessary Noise.

By WEST SUFFOLK: That the Annual Representative Meeting urges the Council of the Association to take steps to secure legislation for the abatement of unnecessary noise.

BRANCH AND DIVISION MEETINGS TO BE HELD.

BIRMINGHAM BRANCH: NUNEATON AND TAMWORTH DIVISION.—A meeting of the Nuneaton and Tamworth Division will be held at the Tamworth General Hospital on Wednesday, April 24th. Dr. K. D. Wilkinson will discuss the causes and treatment of heart failure.

BORDER COUNTIES BRANCH.—A general meeting of the Border Counties Branch will be held at the Crown and Mitre Hotel, Carlisle, on Thursday, April 25th, at 3 p.m. There will be a general discussion on influenza; the following have promised to give short opening addresses: Dr. E. Armstrong, Dr. Duncan Cameron, Mr. E. Craig Dunlop, and Dr. Kenneth Fraser.

GLASGOW AND WEST OF SCOTLAND BRANCH: GLASGOW SOUTHERN DIVISION.—A meeting of the Glasgow Southern Division will be held in the Christian Institute, Eglinton Toll, on Wednesday, April 24th, at 8.15 p.m. Agenda: Report of Executive Committee as to the Scottish scale of minimum commencing salaries for public health medical officers; reconsider the question of the Glasgow Southern Division joining the other three City Divisions and thus forming a Glasgow Division; election of representatives in Representative Body.

LANCASHIRE AND CHESHIRE BRANCH: WARRINGTON DIVISION.—A scientific meeting of the Warrington Division will be held at the Infirmary, Kendrick Street, Warrington, to-day (Friday, April 19th), at 8.30 p.m. Agenda:—Dr. C. Philip Brentnall, *M.C.*: Abortion; Dr. J. S. Manson: Pseudo-hypertrophic paralysis.

METROPOLITAN COUNTIES BRANCH: CAMBERWELL DIVISION.—The annual meeting of the Camberwell Division will be held at St. Giles's Hospital, Camberwell, on Tuesday, April 30th, at 9 p.m. An address, illustrated by lantern slides, will be given by Mr. James R. Ogden, J.P., entitled "Ur of the Chaldees and Babylon."

METROPOLITAN COUNTIES BRANCH: MARYLEBONE DIVISION.—A meeting of the Division will be held at 11, Chandos Street, Cavendish Square, W.1, on Wednesday, April 24th, at 8 p.m. Agenda: Election of officers and representatives; consideration of Report of Central Council; notices of motions for Annual Representative Meeting; honorary secretary's annual report. Members are requested to bring to the meeting their copies of the *Supplement* of April 20th.

METROPOLITAN COUNTIES BRANCH: NORTH MIDDLESEX DIVISION.—A meeting of the North Middlesex Division will be held in the Southgate Council Offices, Palmers Green, on Wednesday, April 24th. Agenda: Ten-minute papers:—Dr. A. W. Gregorson: The medical aspect of sepsis following abortion; Mr. K. A. K. Hudson: The surgical aspect of septic abortion; Dr. G. P. Staunton: Puerperal sepsis in general practice; followed by a discussion.

METROPOLITAN COUNTIES BRANCH: WILLESDEN DIVISION.—The annual meeting of the Willesden Division will be held on May 15th, when the Annual Report of Council will be discussed.

NORTH WALES BRANCH.—The spring meeting of the North Wales Branch will be held, by the kind invitation of the president (Dr. E. I. Spriggs), at Ruthin Castle on Friday, April 26th.

OXFORD AND READING BRANCH: OXFORD DIVISION.—A clinical meeting of the Oxford Division will be held at the Horton Infirmary, Banbury, to-day (Friday, April 19th), at 3 p.m.

TABLE OF DATES.

May 4, Sat.	Last day for receipt at Head Office of nominations: (i) by a Division or not less than 3 members, for election of 24 members of Council by grouped Branches in British Isles; and (ii) for election of 2 Public Health Service members of Council, and 4 Representatives of Public Health Service in Representative Body.
May 14, Tues.	Motions by Divisions and Branches for A.R.M. agenda on matters of which two months' notice must be given must be received at Head Office by this date.
May 18, Sat.	Publication in *Supplement* of motions by Divisions and Branches for A.R.M. on matters of which two months' notice must be given.
	Representatives and Deputy Representatives must be elected by this date.
	Publication in *Supplement* of list of nominations for election of (i) 24 members of Council by grouped Branches in British Isles; (ii) 2 Public Health Service members of Council, and 4 Representatives of Public Health Service in Representative Body.
	Voting papers posted from Head Office where there are contests in above elections.
May 25, Sat.	Last day for receipt at Head Office of voting papers for election, where there are contests, of (i) 24 members of Council by grouped Branches in British Isles; and (ii) 2 Public Health Service members of Council, and 4 Representatives of Public Health Service in Representative Body.
June 6, Thurs.	Names of Representatives and Deputy Representatives must be received at Head Office by this date.
June 8, Sat.	Publication in *Supplement* of result of election of members of Council by grouped Branches, and of result of election of members of Council and Representatives in Representative Body by Public Health Service members.
	Nomination papers available (on application at Head Office) for election of 12 members of Council by grouped Representatives (British Isles).
June 12, Wed.	*Council.*
June 20, Thurs.	Meetings of Constituencies must be held between this date and July 19th, to instruct Representatives.
June 29, Sat.	Supplementary Report of Council appears in *Supplement.*
July 3, Wed.	Amendments and riders for inclusion in A.R.M. agenda must be received at Head Office by this date.
July 19, Fri.	*Annual Representative Meeting*, Manchester.
	Nominations for election of 12 members of Council by grouped Representatives must be received (at A.R.M., Manchester) by this date.
July 20, Sat.	*Annual Representative Meeting*, Manchester.
July 22, Mon.	*Council*, Manchester.
	Annual Representative Meeting, Manchester.
July 23, Tues.	*Annual Representative Meeting*, Manchester. Annual General Meeting, Manchester, President's Address.
July 24, Wed.	*Council*, Manchester. Conference of Honorary Secretaries, Manchester.
	Meetings of Sections, etc., Manchester.
July 25, Thurs.	Meetings of Sections, etc., Manchester.
July 26, Fri.	Meetings of Sections, etc., Manchester.

ALFRED COX, *Medical Secretary.*

Meetings of Branches and Divisions.

FIFE BRANCH.

A CLINICAL meeting of the Fife Branch was held in the Maternity Home, Kirkcaldy, on March 28th, when Dr. ISDALE GREIG, president of the Branch, was in the chair.

Dr. JAMES YOUNG (Edinburgh), who gave an address on the woman damaged by child-bearing, said that about 4,000 women yearly died from child-bearing and childbirth in Great Britain. It was probably an understatement to say that ten times that number—namely, 40,000—yearly lived with their health permanently undermined from the same causes. Referring to the type of woman who had never been in good health since the birth of the last infant, he remarked that this ill health-sterility complex was in the majority of cases derivable from pelvic lesions, which could be divided into the mechanical and infective. In many cases both factors were combined in producing the symptoms, because a woman with lacerations of the soft parts that resulted in displacements was apt during parturition to suffer from septic infection. Among the mechanical causes of ill health Dr. Young referred to prolapse, and pointed out that it was important that this condition be treated early, since otherwise it might lead on to intractable infective lesions in the bladder and kidneys and to permanent structural changes in the alimentary canal from stasis. Another important series of mechanical changes consisted of strains in the sacro-iliac and lumbo-sacral joints; these were commonly the cause of persisting disability. Among infective lesions the most common was infection of the cervix, which caused persisting leucorrhoea, sterility, and iliac fossa and low-back pain. Other infective lesions were discussed, and then Dr. Young referred to chronic kidney disease remaining from pregnancy toxaemia, and to a group of diseases which had an endocrine origin. The simplest had as its clinical picture an increasing adiposity following childbirth, with dryness of the skin, thinning of the hair, and scantiness or suppression of the menses. The complex suggested hypothyroidism, and it often responded well to thyroid medication.

The thoroughly practical manner in which the subject was dealt with and illustrated by the lecturer was much appreciated, and the discussion which followed elicited further points of interest. On the motion of Dr. DOUGLAS a very hearty vote of thanks was accorded to Dr. Young for his address.

THE following officers have been elected for the Fife Branch for 1929:

President, Dr. J. F. Fleming (Dunsley). *President-Elect*, Dr. R. F. Mudie (Ladybank). *Vice-President*, Dr. J. Isdale Greig (Kirkcaldy). *Joint Honorary Secretaries and Treasurers*, Dr. D. E. Dickson (Lochgelly) and Dr. J. M. Johnstone (Leven). *Representative in Representative Body*, Dr. D. E. Dickson (Lochgelly). *Deputy Representative in Representative Body*, Dr. C. E. Douglas (St. Andrews).

METROPOLITAN COUNTIES BRANCH: SOUTH MIDDLESEX DIVISION.

A MEETING of the South Middlesex Division was held at St. John's Hospital, Twickenham, on March 13th: Dr. L. H. F. WALTON read a paper on low backache, with special reference to the group of cases generally designated lumbago, sciatica, or back strain, in which neoplasms, infections, and gross fractures could be excluded.

Dr. Walton divided low backache into two groups—the acute and the chronic. The acute group included fractures, dislocations, subluxations, and torn or sprained muscles or ligaments; while the chronic comprised postural strains, constitutional processes, such as osteo-arthritis and fibrositis, and acute conditions which had become chronic through lack of adequate treatment. He discussed the etiology of these lesions, mentioning, in particular, the softening of the fibrous and ligamentous structures in pregnancy, and prominence of the abdomen. He mentioned the importance of a lateral *x*-ray examination when fractures of the bodies of the vertebrae were concerned. He demonstrated practically the methods of physical examination, mobilization, and manipulation, and showed a number of *x*-ray pictures and various forms of retention apparatus. He described treatment by rest, remedial exercises including deep massage, radiant heat, counter-irritation by ultra-violet light, the galvanic needle, and faradization. He traced an interesting connexion between fibrositis and certain general conditions, mentioning that involvement of the suboccipital triangles was associated with sleeplessness, and that of the left dorsal region with dyspepsia. There was a connexion between flatness of the flat dorsal spine and chronic chest conditions, and also between deposits in the sacral region and constipation. The speaker emphasized the importance of a thorough systematic physical examination in ensuring accuracy of diagnosis, and indicated how careful *x*-ray investigation helped to determine treatment.

SOUTH WALES AND MONMOUTHSHIRE BRANCH: SWANSEA DIVISION.

ON March 7th, at the Swansea General Hospital, Mr. HOWELL W. GABE gave a most interesting address on notes on fifty cases of cholelithiasis. Dr. SLADDEN, chairman of the Division, presided, and a good discussion followed. Mr. Gabe was warmly thanked for a most lucid, able, and stimulating address.

UGANDA BRANCH.

THE annual general meeting of the Uganda Branch was held at Mulago Hospital on January 25th. There was an excellent attendance.

Arising out of the minutes the president, Dr. OWEN, reported that he had interviewed the director of medical and sanitary services regarding the possibility of affording medical officers facilities for attending clinical meetings, and that the director had explained that under colonial regulations no leave, other than local leave, could be granted for this purpose. On the motion of Dr. MARSHALL, seconded by Dr. LANGTON, it was unanimously agreed to ask the Council to suggest to the director of medical and sanitary services on the matter that medical officers within a certain radius of Kampala should be permitted, when possible, to attend as a duty one or two clinical meetings a year, and to point out that the value of such meetings might be comparable to other annual conferences.

The financial statements for 1926-7-8 were submitted, and it was decided to circularize the members, inviting suggestions as to the disposal of the credit balance.

The following officers were elected:

President, Dr. J. P. Mitchell. *President-Elect*, Dr. Stones. *Vice-President*, Dr. A. R. Cook. *Honorary Secretary and Treasurer*, Dr. Reynolds.

Dr. Owen, having vacated the chair, was succeeded by Dr. Mitchell.

A letter dispatched by the retiring Council regarding the regulations for the East African Medical Service (third edition) was considered. The action of the Council was approved; Dr. Owen was authorized to approach the parent body in England and to discuss with it the subject-matter of the letter.

A vote of thanks was accorded to Dr. Owen and the other retiring officers for their services, and also to the staff at Mulago Hospital for their hospitality during the year.

Correspondence.

Security of Tenure.

SIR,—Dr. G. F. Buchan, in his letter under the above heading in the *Supplement* of April 6th (p. 82), invites "M.B." in particular to become acquainted with the activities of his society. Might I suggest that he extends the facility and allows all readers of the *Journal* to know.

There are many who would like to learn what the various specialistic societies of local government medical officers are doing to better the position of the assistant medical officer. For instance, will Dr. Buchan tell us what is the attitude of his society to the subject with which he heads his letter? Admittedly the state of insecurity of the average assistant is pitiable, and a reflection on the organizations purporting to protect his interests. What steps has the society taken in the past, and what steps does it intend taking in the immediate future to improve the security of tenure of the assistant medical officer? The subject is one of general interest, and a statement by Dr. Buchan would be of advantage in clearing up a position which is somewhat mysterious to the onlooker.

So far only one letter by a medical officer of health has appeared in this correspondence, and in it the writer certainly gave no indication that he was dissatisfied with the present state of affairs. In the light of the recent editorial this letter now forms rather curious reading, and one would like to know if chief medical officers accept it as voicing their point of view. If not, it would be only fair if someone entitled to speak for them should say so. I am afraid chief medical officers must face the fact, daily becoming more clearly recognized, that their interests are not necessarily always the same as those of their assistants, and that it is the latter who are principally affected by insecurity of tenure.

"M.B." is quite right in pleading for assistants to be given a share in the effective control of all societies which desire to represent their interests to the outside world. The only alternative would be separate societies for assistants, and these could never thrive under the present state of insecurity which saps the morale of all.—I am, etc.,

Wedmore, Somerset, April 7th. H. C. MCMANUS.

Motor Accidents and Insurance Practitioners.

SIR,—As time goes on the work of the panel doctor increases, but there is one increase which I consider most unfair, and which in a year or two will become a very serious matter—that is, having to attend to motor accidents without a special fee. All motorists are (or shortly will be compelled to be) insured, and if the victim of the accident is not an "insured person" the insurance company pays the doctor's bill; if the victim is an "insured person" the insurance company either saves that fee or the patient pockets it. Patients on the panel often get large compensation for accidents, not only from an insurance company, but from newspapers, etc., but the panel doctor, who may have spent hours attending to the accident, and even in some cases attending the patient for months, cannot claim anything. This, of course, would be of no importance if motor accidents were uncommon, but as 90 per cent. of the motor cyclists are panel patients it is becoming a very serious matter.

Another point is that in my experience drugs and dressings are often required in large quantities, and no provision was made for this when the Drug Fund was fixed, nor should this expense fall on the Drug Fund.—I am, etc.,

Leytonstone, April 11th. ARTHUR T. TODD-WHITE.

Locumtenents' Fees.

SIR,—Is it not time that a stand was made against the excessive fees demanded by locumtenents, mostly newly qualified men with little or no experience? Considering that before the war three to four guineas a week was considered ample, and the fees to private patients have only been raised about 33⅓ per cent., it seems outrageous that seven guineas, or even eight or more, should now be asked. Naturally the agents, who live on commissions, like to keep the fees up, and the only solution seems to be for members of the Association to combine to pay not more than, say, five or six guineas. As everything is found, the fees earned by a locumtenent represent pure gain, nor have they any anxieties as to losing patients like the principal.—I am, etc.,

South Godstone, April 7th. H. E. GIBSON.

GENERAL MEDICAL COUNCIL.

EXECUTIVE COMMITTEE.

MINUTES have now been issued of the meeting of the Executive Committee of the General Medical Council which was held, under the chairmanship of Sir DONALD MACALISTER, on February 25th.

The Schedule of Poisons.

A communication was received from the Privy Council submitting a draft of the changes which the Pharmaceutical Society proposes should be made in the Schedule of Poisons of the Poisons and Pharmacy Act, 1908. The purpose of four of the five amendments is to bring the Schedule into conformity with the Dangerous Drugs Act by making all drugs and preparations to which that Act applies poisons in Part I of the Schedule. The other amendment brings into Part II of the Schedule the "solid lysol tablets" which are now coming on to the market. These contain 15 per cent. of the homologues of carbolic acid, but are at present excluded by virtue of being solid and not liquid preparations. The Executive Committee resolved to inform the Privy Council that it had no objection to make to the proposed changes.

Inspection of Indian Medical Examinations.

A letter from the Secretary to the Government of India, relating to the inspection of medical examinations in India, was brought to the attention of the Committee by the India Office. It stated that the Government of India, after consultation with local Governments, was prepared to create a part-time appointment of inspector of medical examinations, to be held by an officer approved by the General Medical Council. The Government of India pointed out that, as the dates of the medical examinations of some of the Indian universities overlapped, the full programme of inspection would be completed once in two years under the above arrangement. If the Council preferred that the inspection of all Indian medical examinations should be completed in one year it would be necessary to employ at least two inspectors, who would be similarly appointed. It was pointed out in the same letter that the work of inspection and reporting on the medical examinations would not take up more than four months of an officer's time, and that the Government of India had been advised that the inspection of standards of teaching, in so far as proof of the standard attained was not provided by that of the students in the examinations, would not be an annual necessity. The idea of the Government of India was that the work of inspecting examinations should be entrusted to a member of the Indian Medical Service familiar with teaching in India as well as with the requirements of the General Medical Council, and that he should for this additional duty be given an honorarium of Rs400 per mensem. The reply agreed upon by the Executive Committee was that these important matters should be made the subject of a further communication from the Council, but that in the convinced opinion of the Council the only satisfactory solution to the difficulties of inspection of medical colleges and qualifying examinations of Indian universities, until an All-India Medical Council was constituted, was the appointment by the Indian Government of a whole-time commissioner for medical qualifications and standards.

Proposed Public Registration of Chiropodists.

The promoters of a bill, introduced into the House of Lords, providing for the registration of chiropodists forwarded a memorandum for the consideration of the Council. The Committee, after consideration of the memorandum, agreed to adhere to a previous resolution that the Council was not prepared to be associated by law with a body of the kind mentioned in the bill.

Diploma in Public Dentistry.

At a meeting of the Dental Executive Committee (which is the Executive Committee of the General Medical Council with the addition of a dental member) the proposal of the British Dental Association for the institution of a "diploma in public dentistry" analogous to the medical diploma in public health was considered. In the opinion of the Committee no sufficient case was established for the institution of such a diploma.

Dentists and Dangerous Drugs.

At the previous meeting of the Committee Sir Humphry Rolleston was nominated to act on behalf of the Council on the tribunal for dentists to be set up by the Home Office under Section 7 of the Dangerous Drugs Act. The Committee now learned, however, that separate tribunals were to be constituted to deal respectively with the cases of persons practising in England and the cases of persons practising in Scotland, and also that the tribunal was to consist in each case of three registered dentists, one of whom must be appointed on the nomination of the Council. It was agreed, subject to their acceptance, to appoint Mr. Norman Bennett, or alternatively Mr. Evelyn Sprawson, for England, in place of Sir Humphry Rolleston, and to appoint Mr. J. H. Gibbs for Scotland.

National Insurance.

LONDON INSURANCE COMMITTEE.

London Insurance Statistics.

STATISTICS presented to the meeting of the London Insurance Committee, on March 28th, showed that during the year 1928 the number of prescriptions for insulin dispensed was 12,687, the total cost being £5,024. The number of persons for whom these prescriptions were dispensed was 4,735. During the year 2,906 prescriptions were dispensed by chemists for vaccines (2,437 patients), the cost being £558. Practitioners personally dispensed 1,442 prescriptions, 1,124 of them vaccines. The count of the London index register on January 1st, 1929, was 1,916,467, as compared with 1,899,764 on the corresponding date of 1928. The count of the medical register, representing doctors' acceptances, was 1,789,357. The number of persons making their own arrangements at the beginning of the present year was 1,533. The total number applying for change of doctor (in the same district) in 1928 was 24,002, and a further 6,210 applications were made during the first two months of the present year.

Failure to Furnish Regional Medical Officer with Information.

It was reported to the committee that the attention of the Minister had been drawn to the case of a practitioner who had failed to furnish the regional medical officer with certain desired information relative to an insured person who had been referred by the approved society concerned to the regional medical officer for examination. By the terms of service a practitioner is required to furnish in writing to the regional medical officer any information which may be asked for with regard to the case of any patient to whom the practitioner has issued or declined to issue a certificate of incapacity. The Minister had considered whether he ought not to withhold an appropriate portion of the practitioner's remuneration, but in view of the possibility that she had not appreciated the importance of strict compliance with her obligation in this respect, he had decided not to take such action on this occasion. In the event of any further failure to carry out her obligation he would have no alternative.

Accuracy in Dispensing.

A difference of opinion has arisen between the Panel and Insurance Committees in connexion with the tests of dispensing which the Insurance Committee has been carrying out for some time past. The Panel Committee considers that the type of prescription usually selected for analysis is not the best that might be adopted, because in such prescriptions drugs well known to be unstable and variable are frequently employed. Such drugs as calcium chloride, ammonium carbonate, iron perchloride, and quinine sulphate are unsuitable for routine use in testing the accuracy of dispensing, and the regular use of prescriptions containing these preparations tends, says the Panel Committee, to penalize the chemist who has exercised care in dispensing rather than one who has been careless or deliberately fraudulent. The Insurance Committee's analysts, however, reply that three of these substances are important medicinal agents whose stability and variations are well known to pharmacists in general. A very large majority of mixtures containing these substances have been found practically correct, which indicates accurate and careful dispensing by the majority of dispensers. Of the sixty-seven mixtures in the *London Insurance Pharmacopoeia* one or other of these substances is contained in seventeen of the formulae.

LONDON PANEL COMMITTEE.

AT the meeting of the London Panel Committee, on March 26th, under the chairmanship of Dr. H. J. CARDALE, Dr. W. H. Payne was appointed a member of the committee, to fill a vacancy. The resignation of Dr. F. H. Nixey, a member of the committee representing Wandsworth, was accepted with regret.

Temporary Residents.

The relatively large reduction of the London index figures on account of temporary residents, which was before the committee at its previous meeting, was the subject of a report. The view was put forward that one reason for the large reduction was the action of the authorities of the majority of convalescent homes on the south coast, to which the main body of patients from London are sent, in insisting upon the production of the patients' medical cards in order that they can be signed in Part C. Payment is then received by the medical officers of the homes at the temporary resident rates laid down in their respective local distribution schemes. This is done irrespective of whether the patients require treatment or not. The committee has endeavoured to get this state of affairs remedied, but without success. Consideration was adjourned to enable the committee's representative on the Distribution Committee to bring forward some concrete proposal.

Claims for Payment of Anaesthetist.

The committee dealt with a large number of claims for payment of a fee for the provision of an anaesthetist. In 29 cases it allowed a fee of half a guinea for the services of a second practitioner in administering a general anaesthetic in circumstances which were set out, and in 5 other cases allowed a fee of one guinea. In another case the claim for payment of a fee for the anaesthetist was disallowed because the operation was performed by another practitioner as being outside the range of service, the patient being charged a fee, and the patient's insurance practitioner himself administered the anaesthetic, which was within his duty under the terms of service.

Naval and Military Appointments.

ROYAL NAVAL MEDICAL SERVICE.

Surgeon Captain A. R. Schofield to the *President*.

Surgeon Commanders G. A. S. Hamilton to the *Constance*; A. G. McKee to the *Centaur*; J. Kirker to the *Victory* for R.N. Barracks, Portsmouth; F. St. B. Wickham, O.B.E., to the *President*; F. C. Wright to the *Victory* for R.N. Hospital, Haslar; S. W. Grimwade, O.B.E., to the *Victory XI* for R.N. Hospital, Portland; W. H. Murray to the *London*; J. A. Maxwell to the *Frobisher*; A. C. Paterson to the *Marlborough*; H. B. Padwick, D.S.C., to the *Victory* for R.N. Hospital, Haslar; G. G. Vickery, O.B.E., to the *Royal Oak*.

Surgeon Commander T. W. Jeffery, O.B.E., is placed on the retired list with the rank of Surgeon Captain.

Surgeon Lieutenant Commander W. A. Jolliffe to the *Caledon*.

Surgeon Lieutenants J. Y. Woodhouse to the *Renown*; M. Clifford to the *Tiger*; W. Flynn to the Pembroke for R.N. Barracks, Chatham; R. R. Baker, A. J. Burden, and J. J. Benson to the *Bruce*; J. B. Partick to the *London* on transfer of flag; H. P. Williams to the *Frobisher* on transfer of flag; H. E. M. Martin to the *Excellent*; H. L. Duncan to the *Vivid*.

ROYAL NAVAL VOLUNTEER RESERVE.

Surgeon Lieutenant Commander C. C. Elliott, D.S.C., to the *Repulse*.

Probationary Surgeon Lieutenant H. A. M. Whitby to the *Champion*.

Surgeon Sublieutenant A. Elliott to the *Victory* for R.N. Hospital, Haslar.

Probationary Surgeon Sublieutenants S. B. Levy and J. N. Matthews to the *Victory* for R.N. Hospital, Haslar.

ROYAL AIR FORCE MEDICAL SERVICE.

Squadron Leaders E. N. H. Gray to Headquarters, Coastal Area, and J. R. Crolius to Home Aircraft Depot.

Wing Commander R. H. Knowles to No. 21 Group Headquarters.

Flight Lieutenants S. F. Heatley to R.A.F. Depot, Uxbridge; R. Thorpe to the Aeroplane and Armament Experimental Establishment, Martlesham Heath; F. T. Boucher transferred to the Reserve Class D.ii; A. Harvey to Station Headquarters, Heliopolis, Middle East.

Flying Officers N. M. Jerram to R.A.F. Practice Camp, Sutton Bridge; C. J. H. Williams to R.A.F. Practice Camp, North Coates, Fittes.

The following are granted permanent commissions as Flying Officers: D. A. Wilson and F. E. Lipscomb.

VACANCIES.

BATH: ROYAL UNITED HOSPITAL.—(1) House-Physician. (2) Assistant House-Surgeon. Salary £120 and £100 per annum respectively.

BEDFORD COUNTY HOSPITAL.—Assistant House-Surgeon (male, unmarried). Salary £130.

BEDFORDSHIRE COUNTY COUNCIL.—Male Assistant Tuberculosis Officer at Sanatorium (unmarried). Salary £450 per annum.

BIRKENHEAD GENERAL HOSPITAL.—Casualty Surgeon (male). Salary £100 per annum.

BIRMINGHAM: EAR AND THROAT HOSPITAL.—Third House-Surgeon (non-resident). Salary £150 per annum.

BIRMINGHAM GENERAL HOSPITAL.—House-Physician. Salary £70 per annum.

BIRMINGHAM MENTAL HOSPITAL.—Junior Assistant Medical Officer. Salary £350 per annum.

BIRMINGHAM AND MIDLAND EYE HOSPITAL.—Surgical Registrar.

BIRMINGHAM UNIVERSITY.—Assistant Lecturer in the Physiological Department. Stipend £300 per annum.

BRADFORD ROYAL INFIRMARY.—(1) Honorary Physician. (2) House-Physician. (3) Two House-Surgeons. Males, unmarried. Salary for (2) and (3) £150 per annum.

BRIGHTON: ROYAL SUSSEX COUNTY HOSPITAL.—(1) Three Honorary Medical Clinical Assistants. (2) Honorary Clinical Assistant to the Dental Department.

BRISTOL EDUCATION COMMITTEE.—Assistant School Medical Officer (whole-time). Salary £600 per annum.

BRISTOL ROYAL INFIRMARY.—(1) Honorary Medical Registrar. (2) Honorary Registrar to the Ear, Nose, and Throat Department.

BRISTOL UNIVERSITY.—Chair of Physiology.

BURY ST. EDMUNDS: WEST SUFFOLK GENERAL HOSPITAL.—House-Surgeon. Salary £150 per annum.

CANCER HOSPITAL, Fulham Road, S.W.3.—House-Surgeon. Salary £100 per annum.

DARLINGTON GENERAL HOSPITAL.—Senior House-Surgeon (male, unmarried). Salary £150 per annum.

DERBYSHIRE COUNTY COUNCIL.—(1) Resident Medical Superintendent at the Bretby Hall Orthopaedic Hospital. (2) Assistant School Medical Officer. Salary for (1) £750 per annum, rising to £850, and for (2) £600 per annum, rising to £700.

EDINBURGH: ROYAL INFIRMARY.—Secretary and Treasurer. Salary £900 per annum.

ELIZABETH GARRETT ANDERSON HOSPITAL, Euston Road, N.W.1.—(1) Junior Assistant Obstetrician. (2) Assistant Radiologist. Women. Honorarium £100 per annum for (2).

EVELINA HOSPITAL FOR CHILDREN, Southwark, S.E.—(1) Physician to Out-patients (honorary). (2) House-Surgeon (male); salary £120 per annum.

HAMPSTEAD: PARISH OF ST. JOHN.—Junior Resident Assistant Medical Officer at New End Hospital. Salary £200 per annum.

HULL: CITY AND COUNTY OF KINGSTON-UPON-HULL.—Assistant Medical Officer of Health. Salary £600 per annum, rising to £700.

JERSEY GENERAL HOSPITAL.—Visiting Physician and Radiologist. Honorarium £150 per annum.

LIVERPOOL PORT SANITARY AUTHORITY.—Assistant Port Medical Officer. Salary £700 per annum, rising to £800.

LIVERPOOL STANLEY HOSPITAL.—Male House-Physician. Salary £100 per annum.

LONDON FEMALE LOCK HOSPITAL, Harrow Road, W.9.—Honorary Obstetric Surgeon.

LONDON HOSPITAL, E.—Gynaecological First Assistant and Obstetric Tutor. Salary £300 per annum.

LONDON TEMPERANCE HOSPITAL, Hampstead Road, N.W.1.—Surgical Registrar. Honorarium 40 guineas.

MANCHESTER ROYAL INFIRMARY.—First Assistant in the Clinical Laboratory. Salary £350 per annum.

MIDDLESEX COUNTY COUNCIL.—Third Assistant Resident Medical Officer (male) at the County (Tuberculosis) Sanatorium, Harefield. Salary £400 per annum.

MILLER GENERAL HOSPITAL, Greenwich Road, S.E.10.—Out-patient Officer (male, unmarried). Salary £150 per annum.

NEWCASTLE-UPON-TYNE PARISH.—Deputy Medical Superintendent at Wingrove Hospital and Poor Law Institution. Salary £400 per annum.

NEWPORT COUNTY BOROUGH.—Female Supervisor for Mental Defectives. Salary £250 per annum.

NOTTINGHAMSHIRE COUNTY COUNCIL.—Assistant School Medical Officer (male). Salary £600 per annum.

POOLE: CORNELIA AND EAST DORSET HOSPITAL.—House-Surgeon (male). Salary £150 per annum.

QUEEN CHARLOTTE'S MATERNITY HOSPITAL, Marylebone Road, N.W.1.—Resident Anaethetist. Salary £80 per annum.

QUEEN'S HOSPITAL FOR CHILDREN, Hackney Road, E.2.—(1) House-Physician. (2) Casualty Officer. (3) Surgeon for the Ear, Nose, and Throat Department. Salary for (1) and (2) £100 per annum.

ROYAL LIVERPOOL BABIES' HOSPITAL, Woolton.—Resident Medical Officer. Salary £90 per annum.

ROYAL NATIONAL ORTHOPAEDIC HOSPITAL, Great Portland Street, W.1.—Surgical Registrar (male). Honorarium £105 per annum.

ST. BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE, E.C.1.—Senior Curator of the Museum.

ST. HELENS COUNTY BOROUGH.—Assistant Medical Officer of Health (male). Salary £450 per annum.

SAMARITAN FREE HOSPITAL FOR WOMEN, Marylebone Road, N.W.1.—House-Surgeon. Salary £100 per annum.

SHEFFIELD UNION.—House-Physician (lady) at the Nether Edge Hospital. Salary £150 per annum.

SOUTH SHIELDS POOR LAW UNION.—Female Assistant Resident Medical Officer for the Harton Poor Law Institution and Cleadon Children's Homes. Salary £300 per annum, rising to £350.

STROUD GENERAL HOSPITAL.—House-Surgeon (male). Salary £120 per annum.

SUNDERLAND: ROYAL INFIRMARY.—Honorary Physician.

WALSALL GENERAL HOSPITAL.—Junior House-Surgeon. Salary £100 per annum.

WEST BROMWICH AND DISTRICT GENERAL HOSPITAL.—(1) Two Honorary Ophthalmic Surgeons. (2) Honorary Anaesthetists.

WINSLEY SANATORIUM, near Bath.—Assistant Resident Medical Officer (male). Salary £250.

WOLVERHAMPTON AND MIDLAND COUNTIES EYE INFIRMARY.—House-Surgeon. Salary £200 per annum.

WOLVERHAMPTON: ROYAL HOSPITAL.—(1) Resident Medical Officer; salary £150 per annum. (2) Casualty Officer and Resident Anaesthetist; salary £125 per annum.

WOOLWICH AND DISTRICT WAR MEMORIAL HOSPITAL.—House-Surgeon. Honorarium £125 per annum.

WOOLWICH UNION.—Third Assistant Medical Officer at the Plumstead and District Hospital. Salary £300 per annum, rising to £350.

CERTIFYING FACTORY SURGEONS.—The following vacant appointments are announced: Norwich (Norfolk), Kingsclere (Hants), Rhayader (Radnorshire). Applications to the Chief Inspector of Factories, Home Office, Whitehall, S.W.1.

This list of vacancies is compiled from our advertisement columns, where full particulars will be found. To ensure notice in this column advertisements must be received not later than the first post on Tuesday morning.

APPOINTMENTS.

LYTLE, W. J., F.R.C.S., Assistant Surgeon to the Royal Infirmary, Sheffield.

SHARMAN, Albert, M.B., Ch.B.Glas., Extra Dispensary Surgeon, Royal Samaritan Hospital for Women, Glasgow.

UNDERHILL, S. V. H., M.R.C.S., L.R.C.P., Honorary Consulting Surgeon to the Royal Isle of Wight County Hospital, Ryde.

CERTIFYING FACTORY SURGEONS.—C. G. Harper, M.R.C.S., L.R.C.P., for the Market Deeping District (Lincoln); F. G. Harper, M.D.Ed., for the Somercotes District (Lincoln).

DIARY OF SOCIETIES AND LECTURES.

ROYAL SOCIETY OF MEDICINE.

Section of Odontology.—Mon., 8 p.m., Mr. G. Northcroft: The Migration of a Foreign Body; Mr. G. Thomson: Hyperplasia and Hypoplasia; Mr. E. A. Hardy: A Possible Pitfall in a Purely *X*-Ray Diagnosis of a Fractured Mandible; Mr. Sheldon Friel: The Relation of Function to the Size and Form of the Jaws.

Section of Medicine.—Tues., 5 p.m., Dr. O. Leyton: How can we decide whether a Case of Glycosuria should be Treated?; Dr. W. T. Munro: Pulmonary Tuberculosis due to Bovine Tubercle Bacilli. Discussion will follow.

Section of Urology.—Thurs., 5.30 p.m., Dr. P. J. Cammidge: Prostatectomy in Diabetics.

Section of Disease in Children.—Fri., 4.30 p.m., Cases.

Section of Epidemiology.—Fri., 8 p.m., Dr. J. Gordon Thomson: Endemic Malaria in Southern Rhodesia.

MEDICO-LEGAL SOCIETY, 11, Chandos Street, W.1.—Thurs., 8.30 p.m., Lord Riddell: The Sterilization of the Unfit; followed by a discussion.

ST. JOHN'S HOSPITAL DERMATOLOGICAL SOCIETY, 49, Leicester Square, W.C.2.—Wed., 4.15 p.m., Clinical Cases. 5 p.m., Discussion: Alopecia Areata; to be opened by Dr. Roxburgh.

UNIVERSITY OF BIRMINGHAM.—Wed., 4.30 p.m., William Withering Memorial Lecture by Dr. Charles Singer: Epochs of Medical History.

British Medical Association.

OFFICES, BRITISH MEDICAL ASSOCIATION HOUSE, TAVISTOCK SQUARE, W.C.1.

Departments.

SUBSCRIPTIONS AND ADVERTISEMENTS (Financial Secretary and Business Manager. Telegrams: Articulate Westcent, London).

MEDICAL SECRETARY (Telegrams: Mediseca Westcent, London).

EDITOR, *British Medical Journal* (Telegrams; Aitiology Westcent, London).

Telephone numbers of British Medical Association and British Medical Journal, Museum 9851, 9852, 9863, and 9864 (internal exchange, four lines).

SCOTTISH MEDICAL SECRETARY: 7, Drumsheugh Gardens, Edinburgh. (Telegrams: Associate, Edinburgh. Tel.: 24361 Edinburgh.)

IRISH MEDICAL SECRETARY: 16, South Frederick Street, Dublin. (Telegrams: Bacillus, Dublin. Tel.: 4737 Dublin.)

Diary of the Association.

APRIL.

19 Fri. Oxford Division: Horton Infirmary, Banbury, 3 p.m.
Warrington Division: The Infirmary, Kendrick Street, Warrington, 8.30 p.m. Dr. C. Philip Brenthall on Abortion.

23 Tues. London: Grants Subcommittee, 2 p.m.

24 Wed. Glasgow Southern Division: Christian Institute, Eglinton Toll, 8.15 p.m.
Marylebone Division: 11, Chandos Street, Cavendish Square, W., 8 p.m.
North Middlesex Division: Southgate Council Offices, Palmers Green, 3.30 p.m. Papers.
Nuneaton and Tamworth Division: Tamworth General Hospital. Dr. K. D. Wilkinson on the Causes and Treatment of Heart Failure.

25 Thurs. Border Counties Branch: Crown and Mitre Hotel, Carlisle, 3 p.m. Discussion on Influenza.

26 Fri. London: Ante-natal Scheme Subcommittee, 2.30 p.m.
North Wales Branch: Ruthin Castle. Spring Meeting.

30 Tues. Camberwell Division: St. Giles's Hospital, Camberwell, 9 p.m. Mr. James R. Ogden on Ur of the Chaldees and Babylon.

POST-GRADUATE COURSES AND LECTURES.

FELLOWSHIP OF MEDICINE AND POST-GRADUATE MEDICAL ASSOCIATION, 1, Wimpole Street, W.1.—*Queen Mary's Hospital*, Stratford, E.15: Wed., 2 p.m., Ante-natal Demonstration; no fee. *St. John's Hospital for Diseases of the Skin*, Leicester Square, W.C.2: Thurs., 2 p.m., Out-patient Demonstration; no fee. *London School of Hygiene and Tropical Medicine*, Endsleigh Gardens, W.C.2: Tues. and Thurs., Lecture Demonstration at 2 p.m. (proportionate fees). *Royal Free Hospital*, Gray's Inn Road, W.C.1: Wed., 5.15 p.m., Lecture Demonstration (proportionate fees). *Royal Waterloo Hospital*, Waterloo Road, S.E.1: Special Course in Medicine, Surgery, and Gynaecology; £2 2s. for two weeks. *West End Hospital for Nervous Diseases*, 73, Welbeck Street, W.1: Daily Lecture Demonstrations, illustrated by cases at 5 p.m.; £1 11s. 6d. for three weeks. Copies of syllabuses and tickets of admission from the Fellowship of Medicine.

CENTRAL LONDON THROAT, NOSE, AND EAR HOSPITAL, Gray's Inn Road, W.C.1.—Mon., 1.30 p.m., Hearing Tests. Wed., 1.30 p.m., The Larynx. Fri., 1.30 p.m., The Mouth and Pharynx; 4 p.m., Frontal Sinus Operations.

CITY OF LONDON MATERNITY HOSPITAL, City Road, E.C.—Thurs., 5.30 p.m., Abnormal Uterine Action.

NORTH-EAST LONDON POST-GRADUATE COLLEGE, Prince of Wales's General Hospital, Tottenham, N.15.—Mon., 2.30 to 5 p.m., Medical, Surgical, and Gynaecological Clinics; Operations. Tues., 2.30 to 5 p.m., Medical, Surgical, Throat, Nose, and Ear Clinics; Operations. Wed., 2.30 to 5 p.m., Medical, Skin, and Eye Clinics; Operations. Thurs., 11.30 a.m., Dental Clinics; 2.30 to 5 p.m., Medical, Surgical, and Ear, Nose, and Throat Clinics; Operations. Fri., 10.30 a.m., Throat, Nose, and Ear Clinics; 2.30 to 5 p.m., Surgical, Medical, and Children's Diseases Clinics; Operations.

ROYAL DENTAL HOSPITAL OF LONDON SCHOOL OF DENTAL SURGERY, Leicester Square, W.C.2.—Wed., 6 p.m., Some Biochemical Aspects of Saliva.

ROYAL NORTHERN HOSPITAL, Holloway Road, N.—Tues., 3.15 p.m., Tumours.

DERBY MEDICAL SOCIETY, Derbyshire Royal Infirmary.—Tues., 8 p.m., Acidosis.

GLASGOW POST-GRADUATE MEDICAL ASSOCIATION.—At Royal Samaritan Hospital for Women: Wed., 4.15 p.m., Gynaecological Cases.

LIVERPOOL UNIVERSITY CLINICAL SCHOOL ANTE-NATAL CLINICS.—Royal Infirmary: Mon. and Thurs., 10.30 a.m. Maternity Hospital: Mon., Tues., Wed., Thurs., and Fri., 11.30 a.m.

MANCHESTER: ANCOATS HOSPITAL.—Thurs., 4.15 p.m., Modern Urological Methods. Tea served at 3.45 p.m.

MANCHESTER ROYAL INFIRMARY.—Tues., 4.15 p.m., Minor Medical Operations. Fri., 4.15 p.m., Demonstration of Surgical Cases.

BIRTHS, MARRIAGES, AND DEATHS.

The charge for inserting announcement of Births, Marriages, and Deaths is 9s., which sum should be forwarded with the notice not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

BIRTH.

LYLE.—On April 13th, to Alice, wife of J. S. Lyle, M.B., B.Ch., Oakmere, Newton-le-Willows, Lancs, a son.

MARRIAGE.

SMELLIE-LAMSDALE.—On April 10th, 1929, at Sutton Coldfield Parish Church, James Maclure Smellie, M.D., M.R.C.P., to Kathleen, only daughter of Mr. and Mrs. H. Lamsdale of Four Oaks, Sutton Coldfield.

DEATH.

BURTON.—On March 30th, at 49, St. Giles' Street, Norwich, Samuel Herbert Burton, M.B., F.R.C.S.Eng., J.P., aged 75, the most beloved husband of Mary Johanna Burton.

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